

**ATTACHMENT A
Corrective Action Plan Response Form**



Plan Name: Health Plan of San Mateo

Review/Audit Type: DHCS A&I Medical Review Audit

Review Period: August 1 2013 – 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 Documentation	Completion/ Expected Completion Date	DHCS Comments
1. Utilization Management				
1.1.1 No process to ensure consistent application of Utilization Guidelines	<ol style="list-style-type: none"> Develop an Inter-Rater Reliability Policy to ensure consistent application of Utilization guidelines. Perform Inter-Rater Evaluation training for staff making medical necessity decisions, document 	<ol style="list-style-type: none"> HPSM_CAP_1.1.1_UM-11 Inter-Rater Reliability N/A - To be Completed 	<ol style="list-style-type: none"> July 1, 2015 Scheduled July 2015 	<p>There was no mechanism in place to ensure the consistency or appropriateness of medical necessity denials made by Medical Directors.</p> <p><u>Recommendation</u></p> <p>Establish a method of ensuring the consistency of guideline application; to include a method for</p>

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	<p>and report training to UMC.</p> <p>3. Perform Inter-Rater Reliability activities.</p>	<p>3. N/A - To be Completed</p> <p>HPSM_CAP_1.1.1_St aff Training UM Review</p> <p>HPSM_CAP_1.1.1_St aff Training Inpatient UM Review</p>	<p>3. Scheduled July 2015</p>	<p>ensuring denials made by Medical Directors are appropriate and consistent.</p> <p>The Plan submitted an Inter-Rater Reliability Policy which details the methods that will be used to ensure consistent application of Utilizations guidelines. This item remains open. Please provide training materials</p> <p>10-23-15</p> <p>The Plan submitted the training materials for UM Review and Inpatient Review and Care Transitions. This item is closed.</p>
<p>1.1.2 No mechanism to detect under and over-utilization of health care services</p>	<p>1. Complete P&P addressing the Over and Under Utilization</p> <p>2. Convene Utilization Management Committee (UMC)</p>	<p>1. HPSM_CAP_1.1.2_UM-31 Over and Under Utilization</p> <p>2. N/A - To be Completed</p> <p>HPSM_CAP_1.1.2_U M Committee_08-06- 2015</p>	<p>1. June 2015</p> <p>2. August 2015</p>	<p>The Plan only addressed isolated instances of over- and under-utilization. It had no systematic method of detecting overall over-or under-utilization for populations, services, procedures, specialties or Providers.</p> <p><u>Recommendation</u></p> <p>Implement a systematic method of detecting over-and under-utilization for services across the population.</p> <p>The Plan completed its P&P addressing both over and under utilization. The Plan will also convene a Utilization Management Committee in August 2015. This item is provisionally closed. Please submit minutes from the August UMC.</p>

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				<p>10-23-15</p> <p>The Plan submitted the agenda for the August 6, 2015 UM Committee meeting. This item is closed.</p>
<p>1.1.3 UM Program not continuously updated and improved</p>	<p>1. Revise Utilization Management program for 2015.</p>	<p>1. HPSM_CAP_1.1.3_UM Program 2015</p>	<p>1. July 2015</p>	<p>The Quality Improvement (QI) Department was not involved in any efforts to continuously improve the Plan's UM program. QI methodology was not used. Feedback from overturned appeals was not routinely used to improve the Plan's UM program. Denial rates were not used to update or improve the UM program. The Plan did not continuously improve its UM program.</p> <p><u>Recommendation</u> Continuously update and improve the UM program, using QI methodology and data, including data from denial rates and overturned appeals.</p> <p>The Plan updated its UM program for 2015. The UM program states HPSM's UM Program collaborates with the HPSM Quality Management program to ensure ongoing monitoring and evaluation of quality of care and service, and continuous quality improvement. At least annually, the UM Program description, policies, and procedures are reviewed by members of the HPSM Senior Management. The UM Program is revised if necessary. This item is closed.</p>

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1.2.1 Medical necessity denials not reviewed and decided by licensed physician	<ol style="list-style-type: none"> 1. Routine review of letters and NOAs by manager for medical necessity for signatures by a medical director 2. Training for decision making staff related to the differences between a medical necessity denial and 'administrative' denials. 	<ol style="list-style-type: none"> 1. N/A 2. HPSM_CAP_1.2.1_Service Denial Mtg 5-9-14 (sign-in and minutes) <p>HPSM_CAP_1.2.1_Review of Denial Letters</p>	<ol style="list-style-type: none"> 1. Began April 2015; Continuing process 2. May 9, 2014 	<p>Medical necessity decisions that result in a denial of authorization must be made by a licensed physician. A Medical Director's signature on a NOA letter is an attestation that they performed this review. Three of 24 files reviewed in the medical PA verification study sample were medical necessity denials, where the denial Notice of Action (NOA) letter was signed by a Registered Nurse (RN).</p> <p>A focused review of a random sample of 75 medical service PAs was examined to look for the prevalence of this issue: 24% of all NOAs for medical necessity denials were signed by RNs.</p> <p><u>Recommendation</u></p> <p>Document Medical Director review of denial by reason of medical necessity. Require Medical Directors sign medical necessity NOA letters.</p> <p>The Plan submitted the sign-in sheet and minutes for the Service Denial meeting held on 5-9-14. The Plan also stated that since April 2015 medical necessity denial NOAs have been reviewed for medical director signature. To close this item, please provide Evidence that Medical the Director is reviewing NOAs for a one month period. . This item is open.</p> <p>10-23-15</p> <p>The Plan submitted an internal audit of NOAs for Medical Director signatures for the month of</p>

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				September. This item is closed.
1.2.2 Time frames exceeded for Prior Authorization	<ol style="list-style-type: none"> 1. Develop timeliness monitoring tools 2. Train staff on standards of timeliness. 3. Develop process for improvement on timeliness should it fall below standards 4. Effective 1/1/15, HPSM stopped the practice of deferring the pharmacy PA requests for more information as a result of the finding in the November audit. HPSM implemented a response process of making an approved or a denied decision within 24 hours or 1 business day of receipt of the 	<ol style="list-style-type: none"> 1. HPSM_CAP_1.2.2_Daily Auth Report_Example 2. HPSM_CAP_1.2.2_ICE_UM_TAT_CMS_Standards HPSM_CAP_1.2.2_ICE_UM_TAT_Medi-Cal_Standards 3. HPSM_CAP_1.2.2_Quick Recovery of TAT Plan 4. HPSM_CAP_1.2.2_PM.04-01 HPSM PA Process for MCAL_HLines_ICP and ACE 5. HPSM_CAP_1.2.2_ 	<ol style="list-style-type: none"> 1. 8-1-14 2. 7-17-15 3. 6-26-15 4. 1-1-15 	<p>An examination of denials for the Plan's medical services that required a PA disclosed that 10.3% were decided after 28 days, which is by definition exceeding time frame requirements.</p> <p>A sample of 24 PA requests was further examined as part of the verification study. One was over 28 days; eight were greater than 14 days without notification to Member or Provider of the reason for delay, and two were greater than five days after the receipt of all information necessary to render a decision.</p> <p>10 of 20 Pharmacy PA files reviewed in the verification study were not denied or approved within 24 hours or one business day.</p> <p><u>Recommendation</u></p> <p>Process PA requests according to required time frames. Implement systems that ensure adequate resources and reporting mechanisms are in place.</p> <p>The Plan submitted an example of a Daily Authorization Report. Plans to train staff on timeliness standards and modified Policy PM-04-01 regarding the pharmacy prior authorization</p>

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	<p>request.</p> <p>5. Effective 7/1/15, HPSM will comply with the revised contract language received via an email clarification from DHCS regarding plan's response to Pharmaceutical Prior Authorizations. (See attached communication regarding pharmaceutical PA guidance). DHCS states that the clarification represents the standard to which Plans are held accountable and supersedes any recent DHCS Audit findings that were contrary to this clarification.</p>	<p>Email_DHCS Pharmaceutical PA – Final 050815</p>	<p>5. 7-1-15</p>	<p>process. This item is closed.</p>
<p>1.2.3 NOA Letters' explanation of denial decision incomplete and/or inaccurate</p>	<p>1. As of April 2015, HPSM has updated the denial rationale and verbiage in the NOA letters in plan's Letter Generator to contain clear and concise template language.</p> <p>2. The pharmacy technician staff has been trained to write denial letters in clear and concise language including a description of plan criteria used and the clinical reason(s) for the denied</p>	<p>1. HPSM_CAP_1.2.3_LTR GENERATOR</p> <p>2. HPSM_CAP_1.2.3_Communication to Staff and Consultant re_NOA</p>	<p>1. 4/3/15</p> <p>2. 4/3/15</p>	<p>The Plan explained its reason in a Pharmacy denial NOA letter: "the doctor did not give a good reason" for a medicine, when the reason for denial was failure to submit the results of specific required cancer screening. No citation of the criteria used was given, nor any medical necessity explanation. Two Pharmacy denial NOA letters contained an inaccurate statement that "the physician failed to fill out the PA form completely." The Plan was not in compliance with the requirement for a clear and concise explanation of the reasons for medical necessity denials.</p>

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	<p>decision.</p> <p>3. Updated the P&P for Pharmacy Prior Authorization to include language requirements for writing member NOA letter of denials.</p>	<p>3. HPSM_CAP_1.2.3_PM.04-01 HPSM PA Process for HPSM-MCal_HLines_ICP and ACE</p>	<p>3. 7/1/15</p>	<p><u>Recommendation</u></p> <p>Clearly and concisely explain the specific reason, including a description of the criteria used, for denial in NOA letters.</p> <p>The Plan has updated its denial rationale language to be more clear and concise. Pharmacy tech staff was trained to write denial letter with clear and concise language including a description of criteria and clinical reasons for the denials. The Plan also updates Policy 04-01 to include language requirements for writing member NOA denials. This item is closed</p>
<p>1.2.4 Medical information requested that was not reasonably necessary for a determination</p>	<p>1. The pharmacy staff has received information on how to request information that is relevant and necessary to make a determination.</p> <p>2. Updated the P&P for Pharmacy Prior Authorization to include the requirement of requesting only the medical information reasonably necessary to make a determination of medical necessity.</p>	<p>1. HPSM_CAP_1.2.4_Email_PM.04-01</p> <p>2. HPSM_CAP_1.2.4_PM.04-01 HPSM PA Process for HPSM-MCal_HLines_ICP and ACE</p>	<p>2. 7/1/15</p>	<p>The Plan's request for additional information was not reasonably necessary to make a determination. The lack of a response for additional information resulted in an inappropriate denial.</p> <p><u>Recommendation</u></p> <p>Request only the medical information reasonably necessary to make a determination of medical necessity when considering a PA request.</p> <p>The Plan provided its pharmacy staff information on how to request information that is relevant for making a determination. The Plan also updated Policy 04-01 to include the requirement of only requesting information necessary to make a determination of medical necessity. This item is</p>

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				closed.
1.2.5 The Plan did not coordinate medically necessary care as identified by the PA system	<p>1. Staff training to recognize ongoing needs requiring coordination with Case Management or Care Transitions.</p> <p>2. Staff training on case management referrals and encourage face to face meetings with case management team.</p>	<p>1. HPSM_CAP_1.2.5_UM Nurse Mtg Care Coordination Across Teams_2-19-15</p> <p>HPSM_CAP_1.2.5_UM_Coordination of Communication Between teams_2-19-15</p> <p>2. HPSM_CAP_1.2.5_UM_Nurse Mtg Care Coordination Across Teams_2-19-15</p> <p>HPSM_CAP_1.2.5_UM_Coordination of Communication Between teams_2-19-15</p> <p>HPSM_CAP_1.2.5_UM Work Group sign in sheet_2.19.15</p> <p>HPSM_CAP_1.2.5_Ad</p>	<p>1. 2/19/15</p> <p>2. 2/19/15</p>	<p>The Plan's PA system denied medically necessary services which were a covered benefit for administrative reasons.</p> <p><u>Recommendation</u></p> <p>Coordinate care provided to Members by modifying PA requests for multiple services to approve medically necessary subsets, and redirect Members to contracted Providers rather than simply denying medically necessary services.</p> <p>The Plan conducted training on ongoing needs requiring coordination with Case Management or Care Transitions and training on case management referrals and encourage face to face meetings with case management team in order to improve the coordination of necessary care. Provide monitoring results for one month of denials to ensure medically necessary services which were covered were not denied for administrative reasons. This item is provisionally closed.</p> <p>10-23-15</p> <p>The Plan submitted a sample of denials from</p>

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		min Denials Review HPSM_CAP_1.2.5_Samples for Admin Denials Review HPSM_CAP_1.2.5_Admin Denials Review HPSM_CAP_1.2.5_Samples for Admin Denials Review		2015 showing that no administrative denials occurred. This item is closed
1.3.1 No referral tracking.	1. Create Daily Report to track all authorizations in system with no decision to capture open, unused or out of compliance requests. 2. Training for UM Staff on Daily Report to access the assigned work for the day	1. HPSM_CAP_1.3.1_Daily Auth Report_Example 2. HPSM_CAP_1.3.1_UM Minutes_6-13-14 HPSM_CAP_1.3.1_UM Sign in Sheet_6-13-14 HPSM_CAP_1.3.1_UM Minutes_9-9-14 HPSM_CP_1.3.1_UM Sign in Sheet_9-9-14	1. 12/01/14 2. Trainings held 6-13-14 and 9-9-14	<u>Recommendation</u> Track all prior authorized referrals, either directly or through appropriate processes of delegation and oversight. The Plan created a Daily Report to track authorizations and submitted evidence of training for the authorization nurses. This item is provisionally closed. Please provide sample of Prior Authorization tracking for one month.

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1.3.2 UM activities not integrated with Quality Improvement System (QIS)	<ol style="list-style-type: none"> 1. Update UM Program and QI Program 2. Develop and convene Utilization Management committee 3. Utilization Management committee activities to be reported to Quality and reviewed by the Quality Improvement 	<ol style="list-style-type: none"> 1. HPSM_CAP_1.3.2_2015 HPSM Quality Program Description HPSM_CAP_1.3.2_UM Program 2015 2. N/A 3. HPSM_CAP_1.3.2_2015 HPSM Quality Program Description HPSM_CAP_1.3.2_UM Program 2015 HPSM_CAP_1.3.2_Clinical Quality Committee Agenda_10-30-15 	<ol style="list-style-type: none"> 1. July 2015 2. August 2015 3. July 2015 	<p>There was no integration of UM activities with QI, or of UM reports to QIS staff.</p> <p><u>Recommendation</u></p> <p>Integrate referral tracking information with the Quality Improvement System.</p> <p>The Plan submitted its updated UM description and QI program description. The Plan will begin reporting UM committee activities to the QI committee. This item is provisionally closed. Please submit evidence of review of UM committee activities to the QI committee once they begin.</p> <p>10-23-15</p> <p>The Plan submitted the agenda for the Clinical Quality meeting to be held on October 30, 2015. UM activities are to be discussed. This item is closed.</p>
1.4.1 Time frame was exceeded for resolution and notification.	<p><u>Timeliness of Acknowledgment Letters:</u></p> <ol style="list-style-type: none"> 1. Administrative Assistant hired for Grievance and Appeals Unit to assist with clerical duties previously performed by G&A Coordinators, which included the writing and mailing of acknowledgment letters. 	<ol style="list-style-type: none"> 1. HPSM_CAP_1.4.1_Summary of Position Changes_2015 Salary Budget HPSM_CAP_1.4.1_Position Change Request Form for G&A_2015 	<ol style="list-style-type: none"> 1. 02/02/15 	<p>Two 14-day appeal extension letters were not sent to the Member. One appeal acknowledgment letter was sent late and another was not sent.</p> <p><u>Recommendation</u></p> <p>Follow all appeal and letter time frames.</p> <p>The Plan conducted a root cause analysis to</p>

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	<p>2. Conducted a root cause analysis to determine the reason for late acknowledgment letters. Identified weaknesses and inefficiencies in the process. Instituted new process for tracking outstanding acknowledgment letters and discussed new tracking process with staff.</p> <p>3. Created daily report of outstanding acknowledgment letters to ensure that all letters are sent timely. This report is reviewed daily by the G&A Administrative Assistant, who is responsible for mailing acknowledgment letters.</p> <p><u>Timeliness of Extension Letters:</u></p> <p>4. Additional Grievance and Appeals (G&A) Coordinator hired to decrease Coordinator caseload</p> <p>5. Report run to confirm timeliness</p>	<p>2. HPSM_CAP_1.4.1_ Email to Grievance and Appeals Admin Asst_07.01.15</p> <p>3. HPSM_CAP_1.4.1_ Report_GA_ Outstanding ACK Letters_01.07.15</p> <p>4. HPSM_CAP_1.4.1_ Summary of Position Changes_2015 Salary Budget</p> <p>HPSM_CAP_1.4.1_ Position Change Request Form for G&A_2015</p> <p>5. HPSM_CAP_1.4.1_</p>	<p>2. 07/01/15</p> <p>3. Report begun 07/01/15 and reviewed daily. Expected date of 100% timeliness is 08/01/15</p> <p>4. 02/02/2015</p> <p>5. 07/01/15</p>	<p>determine the reason for late letters and hired additional staff. The Plan created a daily report to monitor timelines. This item is closed.</p>

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	<p>of extension letters.</p> <p><u>Timeliness of Resolution Letters:</u></p> <p>6. Additional Grievance and Appeals (G&A) Coordinator hired to decrease Coordinator caseload</p> <p>7. Weekly timeliness report reviewed by G&A Manager and shared with G&A staff.</p>	<p>Timeliness Report_Extension Letters</p> <p>6. HPSM_CAP_1.4.1_Summary of Position Changes_2015 Salary Budget</p> <p>HPSM_CAP_1.4.1_Position Change Request Form for G&A_2015</p> <p>7. Document provided here is from the first meeting and the most recent</p> <p>HPSM_CAP_1.4.1_Staff Meeting Agenda 08.03.14</p> <p>HPSM_CAP_1.4.1_Staff Mtg Sign in Sheet 08.03.14</p> <p>HPSM_CAP_1.4.1_Staff Meeting Agenda 06.22.15</p> <p>HPSM_CAP_1.4.1_Staff Mtg Sign in</p>	<p>6. Hire date 02/2/15</p> <p>7. Began 08/03/14, continued weekly</p>	

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	8. Confirmation of timely closure of Medi-Cal 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.	Sheet 06.22.15 8. HPSM_CAP_1.4.1_ Timeliness Report Case Resolution	8. 6/26/15	
1.4.2 Appeal letters were not translated into threshold language.	<p>1. On September 9, 2014, the applicable policy, <i>GA-08 Member Appeal Procedure for Non-Medicare Lines of Business (Section 5.15)</i> was updated to include specific guidance regarding the translation of all member grievance letters into a member's preferred language.</p> <p>2. In order to track the Grievance and Appeals (G&A) Unit's implementation of this requirement, a new data field was created in the G&A System, Everest, to indicate that a translated letter is required. This new data field was discussed with G&A staff at a staff meeting on April 20, 2015.</p> <p>3. Report comparing a member's preferred language, as indicated on his/her eligibility file, to the language of his/her appeal letters confirms that all members with a preferred language other than English have received translated letters. The report included appeals received between</p>	<p>1. HPSM_CAP_1.4.2_ GA-08 Appeals Process_NonMedicare LOBs</p> <p>2. HPSM_CAP_1.4.2_ G&A Staff Mtg Minutes_04.20.15-R</p> <p>3. HPSM_CAP_1.4.2_ Report of Translated Letters_Appeals_ 07.10.15</p>	<p>1. 09/09/14</p> <p>2. 4/20/15</p> <p>3. 07/10/15</p>	<p>There were four acknowledgment letters, four resolution letters and one combination acknowledgment/resolution letter which were not sent to the Member in the threshold language of Spanish.</p> <p><u>Recommendation</u></p> <p>Translate all appeal letters to threshold languages.</p> <p>The Plan submitted an amended Member Appeals Procedure, inserted a translation field in their G&A system and created a report for the status of translated appeal resolution letters. This item is open. Procedure: GA-08 states</p> <p>To comply with regulatory timeframes, the English version of a resolution letter must be mailed within the timeframe (e.g. 30 days for standard grievance) and the Member must be notified verbally of the resolution in his or her preferred language. G&A Coordinators must use HPSM's contracted telephonic interpreting service to provide verbal notification if they are not fluent in the member's preferred language.</p>

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	04/1/2015 and 07/10/2015.			<p>Appeal resolution letters must be translated and mailed to the member within the required timeframe if the member's preferred language is Spanish, Chinese or Tagalog. Verbal notification cannot be used as a substitute. The language in the policy is acceptable for languages other than Spanish, Chinese or Tagalog. Please amend Procedure GA-08 to state that appeal resolution letters will be translated (in the required threshold languages of the county) and mailed to the member with in the required timeframe.</p> <p>1-11-16:</p> <p>The Plan updated to Policy GA-08 to ensure that Appeal Resolution Letters are resolved, translated and sent to the member within the contractually required timeframe. This item is closed.</p>
1.4.3 Communication to Members and Providers during appeals were not consistent, clear or concise.	1. The deficiency checklist referred to in this finding was used in processing an appeal for Sovaldi, a Hepatitis C medication. At the time of this case, the State of California had not released guidance on the criteria for authorizing coverage of this drug. HPSM's Associate Medical Directors began using the State guidance on 6/26/14, when it was released by DHCS. As of 6/26/14, HPSM does not	<p>1. HPSM_CAP_1.4.3_Medical Director Decision_Example</p> <p>HPSM_CAP_1.4.3_Member Resolution Letter_Example_Uphe Id Harvoni Appeal</p> <p>HPSM_CAP_1.4.3_Letter to</p>	1. 06/26/14	<p>The Plan sent inconsistent data to the Member and Provider, making it difficult for the Member and Provider to provide the Plan with missing information.</p> <p><u>Recommendation</u></p> <p>Consistently and clearly communicate all requirements to Providers and Members.</p> <p>Consistently and clearly communicate all</p>

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	<p>use deficiency checklists internally or in its communications to Members or Providers for Hepatitis C medications, thereby eliminating any cause for confusion. Attached is an example of the documentation provided by the Associate Medical Director regarding a recent Sovaldi appeal, as well as the communication sent to the Member and Provider. Also attached is the State guidance now used by HPSM for all coverage decisions and appeals for Hepatitis C drugs.</p> <p>2. Discussed DHCS audit findings with Grievance and Appeals (G&A) staff on May 4, 2015. This discussion included a review of the importance of communicating clearly with both Member and Providers and ensuring that both parties are receiving the same information about a case.</p> <p>3. Grievance and Appeals Manager and Senior Communications Specialist conducted training for G&A Coordinators responsible for writing Member and provider letters. Training focused on communicating clearly through writing, while at a 6th grade level.</p>	<p>Provider_Example</p> <p>HPSM_CAP_1.4.3_California State Guidance on Hepatitis C Drug Approvals</p> <p>2. HPSM_CAP_1.4.3_G&A Staff Meeting Minutes_05.04.15</p> <p>HPSM_CAP_1.4.3_G&A Staff Meeting Sign in Sheet_05.04.15</p> <p>3. HPSM_CAP_1.4.3_Writing Training Materials_02.20.15</p> <p>HPSM_CAP_1.4.3_Writing Training Sign in Sheet_02.20.15</p> <p>HPSM_CAP_1.4.3_Writing Training Follow up Sign in Sheet_03.25.15</p>	<p>2. 05/04/15</p> <p>3. 02/20/15 and 03/25/15</p>	<p>requirements to Providers and Members.</p> <p>As of HPSM does not use deficiency checklists internally or in its communications to Members or Providers for Hepatitis C medications which was mentioned in the initial finding. The Plan conducted training for grievance coordinators focusing on communicating clearly through writing. This item remains open. Submit evidence of internal auditing to ensure that communication to members and providers during appeals are clear and concise.</p> <p>10-23-15</p> <p>The Plan submitted an internal audit of grievances to ensure that clear and concise language was used. This item is closed.</p>

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<p>1.5.1 No quarterly reporting on delegated activities by UM delegated entity.</p>	<p>1. Update workplan with San Mateo Behavioral Health & Recovery Services to produce UM reporting for Medi-Cal mild-moderate population</p> <p>2. Produce UM data on Medi-Cal mild-moderate population</p> <p>3. Establish quarterly reporting for continuous monitoring of UM activities</p> <p>4. Conduct annual oversight audit of UM activities</p>	<p>1. HPSM_CAP_1.5.1_BHRS_Work Plan Update</p> <p>2. HPSM_CAP_1.5.1_BHRS UM Data and Status Update</p> <p>3. N/A: To be completed</p> <p>4. N/A: To be completed</p>	<p>1. 3/13/15</p> <p>2. 6/5/15</p> <p>3. 11/20/15</p> <p>4. 12/18/15</p>	<p>The Plan entered into a delegation agreement for behavioral health services during the audit period. The agreement required quarterly reports to fulfill the Plan's monitoring requirements. The Plan did not enforce this requirement and did not receive any quarterly reports. The Plan did not continuously monitor the delegated entity.</p> <p><u>Recommendation</u></p> <p>Continuously monitor delegated activities, including quarterly reporting of UM activities (appeals, denials, deferrals and modifications). Conduct annual oversight audits to evaluate all delegated UM activities.</p> <p>The Plan updated its work plan with San Mateo Behavioral Health & Recovery Services to produce UM reporting for Medi-Cal mild-moderate population and produced UM data on Medi-Cal mild-moderate population. The Plan will establish quarterly reporting for continuous monitoring of UM activities and Conduct annual oversight audit of UM activities. This item is provisionally closed. Please submit Quarterly reports of UM activities when they are available</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
2. Case Management and Coordination of Care				
2.1.1 Requirements for Basic Case Management were not met.	<ol style="list-style-type: none"> 1. Monthly case management list will be sent to county clinics specifying the number of days left for member to be seen by provider to ensure completion of IHA in 120 days. 2. Eligibility list to be separated from pediatrics and adult members for clinic outreach efforts 3. Provider service representatives will train all new providers during orientation on accessing provider portal and all existing providers during outreach attempts. Develop policy and procedure for training guidelines of new and existing providers. 	<ol style="list-style-type: none"> 1. HPSM_CAP_2.1.1_Case Management List_Example 2. N/A: To be Completed 3. N/A: To be completed <p>HPSM_CAP_2.1.1_P S 01-03 Provider Training Procedure</p> <p>HPSM_CAP_2.1.1_IH A Training Report_New Providers</p>	<ol style="list-style-type: none"> 1. Started May 2015 and Monthly ongoing 2. Planning began June 2015; Implementation August 2015 3. August 2015 	<p>The Plan did not ensure that IHAs were completed within 120 calendar days from enrollment (see section 2.4 of this report). The Plan did not fully perform its responsibilities as outlined by Memorandum of Understanding (MOU) with the local Regional Center/Early Start (see section 2.3).</p> <p><u>Recommendation</u></p> <p>Provide Basic Case Management</p> <p>The Plans submitted an example of the Monthly Case Management list that will be sent out to clinics specifying the number of days left for member to be seen by provider to ensure completion of IHA in 120 days. Training will be provided to all new providers and a new policy and procedure will be developed for training guidelines of new and existing providers. This item is provisionally closed. Please submit the new training procedure.</p> <p>10-23-15</p> <p>The Plan submitted the training procedure for new providers, which includes training on IHAs. This item is closed</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
2.1.2 Requirements for Complex Case Management were not met	<p>1. Revise and update policy on care coordination and case management</p> <p>2. Implement care management system to identify, track, and case manage eligible members</p> <p>3. Train staff on complex case management and documentation of case management activities</p> <p>4. Monitor complex case management activities</p>	<p>1. HPSM_CAP_2.1.2_CC-01 Care Coordination and Case Management Program</p> <p>2. HPSM_CAP_2.1.2_MedHOK Screenshot</p> <p>3. HPSM_CAP_2.1.2_Care Coord MedHOK Workflow Review_012815</p> <p>HPSM_CAP_2.1.2_Care Coord MedHOK Workflow Review Sign In_012815</p> <p>HPSM_CAP_2.1.2_Swim Lanes for New Case Review_012815</p> <p>HPSM_CAP_2.1.2_Model of Care Training_New Hires_033015</p> <p>4. HPSM_CAP_2.1.2_Care plan completion report_sample</p>	<p>1. Policy revised 12/2014 and 5/2015</p> <p>2. Care management system implemented 01/2015</p> <p>3. Staff trainings 01/2015-03/2015</p> <p>4. 01/2015 and ongoing</p>	<p>Although the Plan's case management staff identified Members for case management based on costs, high utilization or predictive modeling, the Plan did not use this information to identify or refer Members to its Complex Case Management.</p> <p>Multiple Plan Providers were interviewed and all reported no knowledge of the Plan's Complex Case Management policies, procedures or services.</p> <p><u>Recommendation</u></p> <p>Meet all Complex Case Management requirements.</p> <p>The Plan submitted Care Coordination Staff Meeting MedHOK Documentation Review Training and training materials (1/28/2015), sample of Care Plan Completion report (report end date: 7/3/2015), revised P&P CC01 - : Care Coordination Program (approved date 5/8/2015). Plan has provided trainings and has revised the P&P appropriately. This item is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
<p>2.1.3 Policy and procedures did not meet contract requirements. The Plan shall maintain procedures for monitoring the coordination of care provided to Members.</p>	<p>1. Care Coordination and Case Management Policy was revised and updated 12/2014 and 05/2015 to describe complex case management and related tasks</p>	<p>1. HPSM_CAP_2.1.3_CC-01 Care Coordination and Case Management Program</p>	<p>1. Revised: 12/2014 and 5/2015</p>	<p>The policy did not contain a definition, procedures or processes for Complex Case Management as required by the <i>Contract Amendment</i>.</p> <p><u>Recommendation</u></p> <p>Adopt policy and procedures that meet the requirements of the Contract Amendment.</p> <p>The Plan made appropriate revisions to its policy and procedures regarding Complex Case Management. This item is closed.</p>
<p>2.3.1 The Plan did not fulfill responsibilities for ongoing communication to resolve operational, administrative and policy issues as frequently as required by its Memorandum of Understanding for the coordination of services</p>	<p>1. Schedule and conduct regular, quarterly meetings with local regional center</p> <p>2. Document meetings through attendance and summary</p>	<p>1. N/A</p> <p>2. HPSM_CAP_2.3.1_HPSM GGRC BHRS Meeting_12-16-14</p> <p>HPSM_CAP_2.3.1_HPSM GGRC BHRS Meeting_04-03-15</p> <p>HPSM_CAP_2.3.1_</p>	<p>1. Completed 12/16/14; 04/03/15; 06/03/15</p> <p>Future meetings scheduled: 09/09/15 11/04/15</p> <p>2. Completed 12/16/14; 04/03/15; 06/03/15</p>	<p>According to the <i>MOU</i>, the Plan's liaison would meet with the local Regional Center/ Early Start staff to ensure ongoing communication and to resolve operational, administrative and policy issues. The <i>MOU</i> required that this meeting occur at least semi-annually. One of the <i>MOU</i> specified meetings did not take place. The Plan's liaison met with Regional Center/ Early Start staff only once during the audit period, on February 2014.</p> <p><u>Recommendation</u></p> <p>Hold all meetings as required by the <i>MOU</i>.</p> <p>This finding is closed. Awaiting new direction from DMHC.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
		HPSM GGRC BHRS Meeting_06-03-15		
2.4.1 The Plan did not ensure that IHAs for new Members were completed within 120 calendar days of enrollment	<ol style="list-style-type: none"> 1. Monthly case management list will be sent to county clinics specifying the number of days left for member to be seen by provider to ensure completion of IHA in 120 days. 2. Eligibility list to be separated from pediatrics and adult members for clinic outreach efforts 3. Provider service representatives will train all new providers during orientation on accessing provider portal and all existing providers during outreach attempts. Develop policy and procedure for training guidelines of new and existing providers. 4. Change E-Reports IHA instructions in Provider Web Portal, to be completed within 90 days vs. 120 days, due to 30 day lag in new member PCP 	1. HPSM_CAP_2.4.1_Case Management File_Sample	<ol style="list-style-type: none"> 1. Started May 2015 and Monthly ongoing 2. Planning June 2015, Implementation August 2015 3. August 2015 4. Q3 2015 	<p>A verification study of 20 Member records was conducted. Four had no medical records on file and four had missing, incomplete or late IHAs.</p> <p><u>Recommendation</u></p> <p>Ensure that new Members receive an IHA within 120 calendar days of enrollment.</p> <p>The Plan submitted an example of the Case Management File which contains the due date for the members HIS as well as a report that updates member demographic changes to help providers contact members. Provider service representatives will train all new providers during orientation on accessing provider portal and all existing providers during outreach attempts. The Plan will also modify language in its E-Reports. This item is provisionally closed. Please submit internal audit for IHAs for one month.</p> <p>10-23-15</p> <p>The Plan submitted its monthly IHA completion trendline. Showing that the Plan is monitoring IHA completion. Please continue to take the necessary steps to ensure providers complete IHAs for new member within 120 days. This</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>assignment period.</p> <p>5. Update E-reports member assignments with member demographic changes; phone numbers, addresses, on a real time basis, to facilitate providers' ability to contact patients to schedule an IHA.</p> <p>6. 6. Submit copy of new verbiage in member assignment E-Report to state "Complete IHA within 90 days" vs. "120 days" due to members' self-enrollment period is 30 days, so by the time a member is assigned PCP only has 90 days vs. 120 days to complete an IHA.</p>	<p>5. HPSM_CAP_2.4.1_Medi-Cal Case Mngment List_Sample</p> <p>HPSM_CAP_2.4.1_IH A completion_Trendline</p>	<p>5. Started May 2015 and Ongoing Monthly</p> <p>6. Q3 2015</p>	<p>item is closed.</p>
3. Access and Availability of Care				
<p>3.1.1 The Plan's Procedure for monitoring time to obtain various appointments was not valid</p>	<p>1. Collect third-next available appointment data from large organizational providers</p>	<p>1. HPSM_CAP_3.1.1_TNAA Appointment data-NEMS</p> <p>HPSM_CAP_3.1.1_TNAA Appointment data-Planned Parenthood</p> <p>HPSM_CAP_3.1.1_TNAA Appointment data-Ravenswood Clinic</p>	<p>1. Completed, 3/24/15 (and ongoing)</p>	<p>An examination of the methodology disclosed that it presented a risk of not being valid. It measured the percentage of Providers responding "yes" to questions asking if they were compliant. The Plan did not demonstrate that this number actually reflected compliance with access standards. A number of facts indicated that the method was not valid:</p> <p><u>Recommendation</u></p> <p>Develop and implement a valid method to</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>2. Adopt DMHC audit methodology for 2015 Timely Access Survey</p> <p>3. Increase frequency of appointment availability phone survey from annual to biannual</p>	<p>HPSM_CAP_3.1.1_TNAA Appointment data-San Mateo Medical Center</p> <p>2. HPSM_CAP_3.1.1_HPSM-Ravenswood Agenda_05-08-15</p> <p>HPSM_CAP_3.1.1_HPSM-PAMF Agenda_06-10-15</p> <p>3. HPSM_CAP_3.1.1_Timely Access_2015</p>	<p>2. 12/31/15</p> <p>3. 8/15/15</p>	<p>monitor Provider compliance with all access standards.</p> <p>Plan has submitted agendas for 2 meeting with subcontractors to discuss Timely Access (dates: 5/8/15 & 6/10/2015), also plan has submitted 1Q Third Next available Appointment Report from 3 subcontractors. This item is closed.</p>
<p>3.1.2 No Corrective Action Plan for Providers who are non-compliant with timely access standards</p>	<p>1. Meet with San Mateo Medical Center to present findings on access</p> <p>2. New contract with San Mateo Medical Center to improve overall capacity, expand access to specialty care, and develop telephonic access and referral system</p> <p>3. Confirm that survey results for Palo Alto Medical Foundation were not indicative of actual barriers to timely appoint access</p>	<p>1. HPSM_CAP_3.1.2_SMMC_follow up on Timely Access</p> <p>2. HPSM_CAP_3.1.2_Contract with SMC Health System MCE 2014</p> <p>3. HPSM_CAP_3.1.2_PAMF follow up on Timely Access</p>	<p>1. Completed, 5/5/14</p> <p>2. Completed, 10/21/14</p> <p>3. Completed, 10/3/14</p>	<p>The Plan held meetings with the Providers to address issues identified in the Provider Survey. However, there was no written proposal by the Provider for corrective action and no follow-up by the Plan to verify the Provider corrected the deficiencies.</p> <p><u>Recommendation</u></p> <p>Develop and implement a Corrective Action Plan (CAP) for Providers identified to be out of compliance with timely access standards.</p> <p>The Plan submitted examples of requiring providers to submit plans of corrective action for</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	4. Issue Corrective Action Letters to non-compliant providers	4. HPSM_CAP_3.1.2_Kannan Corrective Action Letter	4. Completed, 3/9/15	non-compliance with timely access standards. This item is provisionally closed. Please submit examples of corrective action plans submitted by providers for non-compliance with timely access standards.
3.1.3 No monitoring of wait time for first prenatal visit.	1. Target providers of first prenatal visit (obstetricians) in Timely Access surveys	1. HPSM_CAP_3.1.3_Timely Access Survey_2015	1. 12/31/15	<p>The Plan did not monitor waiting times to obtain initial prenatal care appointments or ensure that the first prenatal visit for a pregnant Member was available within two weeks.</p> <p><u>Recommendation</u></p> <p>Monitor waiting times for the initial prenatal visit and ensure that the first prenatal visit is available within the required time frame.</p> <p>Please submit evidence that shows the waiting times for initial prenatal appointments meet contract requirements.</p> <p>This item is provisionally closed. Awaiting new direction from DMHC.</p>
3.1.4 No monitoring of wait times at Providers' offices and times for Providers to answer phone and return calls.	<p>1. Piloting approach with local FQHC, Ravenswood Family Health Center, to monitor time between reception check-in and start of exam room visit</p> <p>2. Phone answer time tracked as part</p>	<p>1. HPSM_CAP_3.1.4_HPSM-Ravenswood Agenda_05-08-15</p> <p>2. HPSM_CAP_3.1.4_</p>	<p>1. Ongoing, expected date of completion 12/1/15</p> <p>2. August 15,</p>	The Plan's Policy did not state how the 45 minutes standard would be monitored. The Plan did not monitor waiting times in Providers' offices and times for Providers to answer telephone and return calls.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	of 2015 Timely Access surveys	Timely Access Survey_2015	2015	<u>Recommendation</u> Develop and implement a system to monitor waiting time at Providers' offices, and times for Providers to answer telephone and return calls. This item is provisionally closed. Awaiting new direction from DMHC.
3.1.5 Access grievances not reviewed by the Plan's Quality Committee.	1. Plan's Quality Assurance and Improvement Committee will review aggregate Grievance & Appeals reports semi-annually and provide necessary direction based on findings.	1. HPSM_CAP_3.1.5_QAIC Minutes_3-26-15 HPSM_CAP_3.1.5_QAIC Agenda_6-24-15	1. Started Q2 2015 and ongoing	Access Grievances were not reviewed by the Quality Committee as indicated by the Committee minutes and Plan staff. 23 of 97 Member grievances were due to access issues during the audit period. <u>Recommendation</u> Review Access grievances and present this information to the Quality Improvement Committee. The Plan submitted the minutes from 3-26-15 QAIC meeting which shows that access grievances will be discussed in future meetings and the agenda for the QAIC meeting which contains a grievance and appeals update. This item is closed.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
3.1.6 No procedures for follow up on missed appointments in the Plan's Policy	<p>1. Develop procedure for follow up on missed appointments.</p> <p>2. Implement procedure</p>	<p>1. HPSM_CAP_3.1.6_ Member Services Missed Appointment Desk Procedure</p> <p>2. HPSM_CAP_3.1.6_ Email about Excessive No Show</p> <p>HPSM_CAP_3.1.6_ Outgoing Call Regarding Excessive No Show</p>	<p>1. July 2015</p> <p>2. July 2015</p>	<p>The Plan did not have a policy that included procedures for follow up on missed appointments. The Plan had no tracking system for missed appointments.</p> <p><u>Recommendation</u></p> <p>Develop and implement policies and procedures to follow-up on missed appointments.</p> <p>The Plan submitted a desktop procedure for following up on missed appointments. The Plan also submitted an example of member services implementing the procedure by following up on a member's missed appointments. This item is closed</p>
3.3.1 Insufficient Member Services staffing at call center	<p>1. HPSM's fiscal year is January 1 through December 31. Each year during the HPSM budget preparation process, Member Services management reviews the Member Services staffing against metrics such as staff:member ratio. Additional Member Services Representative (MSR) positions are requested during the budget process as determined necessary to meet member and departmental needs. During the 2015 budget process, two additional MSR</p>	<p>1. HPSM_CAP_3.3.1_ Member Services Representative FTE Count by Fiscal Year (shows # of budgeted MSR positions by fiscal year for 2007 -2015. Four MSR positions have been added since 2007; an increase in staffing of 67%. Two MSR positions were added in fiscal year 2015 which began 1/1/2015)</p> <p>HPSM_CAP_3.3.1_ Position Change Request Form for MS FY2015</p>	<p>1. Member Services Dept. staffing is monitored annually.</p>	<p>The Plan is required to maintain sufficient Member Services staff to provide covered services to Members</p> <p><u>Recommendation</u></p> <p>Ensure Member Services maintains sufficient staff to provide covered services to Members.</p> <p>The Plan increased its Member Services staff by an additional two representative and decreased its abandonment rate for 2015. No member grievances were received from 11/1/15 through 6/30/15 due to a member being unable to reach a live person. This item is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>positions were requested and approved. The Member Services staffing will be re-evaluated during the 2016 budget preparation process.</p> <p>2. The HPSM Member Services Department has a staff of Program Specialists; the Program Specialists function as lead workers that are assigned specific functions within the Department. The Program Specialists are also scheduled to provide phone coverage during Member Services Representative staffs' breaks and lunches. The Program Specialists are assigned to cover a Member Service Representative during his/her break/lunch. The staffing schedule is reviewed on a regular basis.</p> <p>3. Managers reviewed member grievances received from 11/1/2014 through 6/30/2015 to identify any complaints that are due to a member being unable to reach a live person</p>	<p>2. HPSM_CAP_3.3.1_Member Services Staff Schedule 6.19.15 (shows the specific times that the Program Specialists cover the call center queue during Member Services staffs' breaks and lunches. Specific Program Specialists are assigned to cover for specific Member Services Representatives)</p> <p>3. HPSM_CAP_3.3.1_Email-Report of Grievances About Call Center Hold Times_Wait Times</p> <p>4. HPSM_CAP_3.3.1_ACD ABD_Flow</p>	<p>2. 6/19/2015 Staff scheduling process will continue.</p> <p>3. 7/2/2015; review of grievances will continue.</p>	

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>in the Member Services call center or for being placed on hold for a long period of time. No member complaints were received during that time.</p> <p>4. Continue to monitor weekly/monthly/quarterly Automated Call Distribution (ACD) reports for Member Services call center.</p>	Out_Q1_Q2 2015	4. ACD reports through June 2015 have been completed. ACD reporting will continue.	
3.3.2 The Plan did not maintain knowledgeable Member Services staff, and did not take corrective action when call monitoring deficiencies were identified	<p>1. The following process has been in place for call monitoring:</p> <p>a) The Training Specialist continues to review 3 calls per Member Services Representative per month;</p> <p>b) the Training Specialist completes a call monitoring form for each call monitored;</p> <p>c) the call monitoring forms are given to the Member Services</p>	<p>1. HPSM_CAP_3.3.2_MS-01-08_Member Services Rep Call Monitoring</p> <p>Call monitoring forms: HPSM_CAP_3.3.2_November 2014 (folder)</p> <p>HPSM_CAP_3.3.2_December 2014 (folder)</p> <p>HPSM_CAP_3.3.2_January 2015 (folder)</p>	<p>1. Monthly call monitoring completed for the review period.</p> <ul style="list-style-type: none"> 11/2014 through 4/2015; forms are included here. 	<p>The Plan's Member Services Representatives Monitoring Reports identified the provision of inaccurate information to Members as a problem. A total of 33 monitored calls for six Member Services Representatives were reviewed for the months of September 2013 and June 2014</p> <p><u>Recommendation</u></p> <p>Maintain knowledgeable Member Services staff. Take corrective actions when call monitoring deficiencies are identified.</p> <p>Please provide evidence that plan has taken an appropriate action to improve the level Member Services Staff knowledge to prevent any</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>Supervisor when completed;</p> <p>d) the Member Services Supervisor reviews the call monitoring forms with each Member Services Representative during one-on-one meetings; some calls may be reviewed with Member Services Representative prior to the one-on-one meeting</p> <p>e) the Member Services Representative signs the call monitoring form;</p> <p>f) the Member Services Supervisor maintains copies of the signed call monitoring forms and notes from the one-on-one meetings.</p>	<p>HPSM_CAP_3.3.2_ February 2015 (folder)</p> <p>HPSM_CAP_3.3.2_ March 2015 (folder)</p> <p>HPSM_CAP_3.3.2_ April 2015 (folder)</p> <p>HPSM_CAP_3.3.2_ May 2015 (folder)</p> <p>HPSM_CAP_3.3.2_M ay 2015</p> <p>HPSM_CAP_3.3.2_Ju ne 2015</p> <p>HPSM_CAP_3.3.2_Jul y 2015</p> <p>HPSM_CAP_3.3.2_Au gust 2015</p>	<ul style="list-style-type: none"> Monthly monitoring will continue. 	<p>miscommunication with the members.</p> <p>This item remains open.</p> <p>10-23-15</p> <p>The Plan submitted examples of call monitoring performed on Member Services staff. The Member Services Supervisor conducts one-on-one meetings with staff to discuss areas the Member Service rep needs to improve. This item is closed.</p>
<p>3.5.1 The Plan did not pay all claims from Providers for emergency services</p>	<p>1. Update HPSM's policy for non-contracted emergency claims to include payment to non-Medi-Cal providers.</p> <p>2. Reconfigure system to allow claims for emergency services to pay when billed by a non-Medi-Cal provider.</p>	<p>1. HPSM_CAP_3.5.1_CO.02-01 Noncontracted Emergency Physician Services_Medi-Cal</p> <p>2. HPSM_CAP_3.5.1_ Internal Request to update Set-up</p>	<p>1. March, 2015</p> <p>2. March, 2015</p>	<p>A review of claims showed that the Plan denied emergency services claims for two out-of-state Providers (Hawaii and New York) and two non-Medi-Cal Providers in California.</p> <p><u>Recommendation</u></p> <p>Pay for emergency services claims from non-contracted Provider.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	3. Develop weekly oversight reports reviewed by Senior Auditor to ensure payment of emergency claims billed by non-Medi-Cal providers are paid.	3. HPSM_CAP_3.5.1_ Emergency and Urgent care services denied in state HPSM_CAP_3.5.1_ Weekly Report EU1500_sample HPSM_CAP_3.5.1_ Out of State Non Medi-Cal Provider HPSM_CAP_3.5.1_ Weekly Report_OS NonMC Provider_sample	3. March, 2015	The Plan updated policy CO.02-01 to include payment to non-Medi-Cal providers. The Plan also reconfigured its system so that emergency service claims can be paid to no-Medi-Cal providers. Weekly oversight reports will be developed and reviewed to ensure payments of emergency claims billed by non-Medi-Cal providers are paid. This item is closed.
3.5.2 The Plan did not forward claims to the appropriate provider within 10 days of receipt	1. Develop weekly automated report to capture all misdirected claims for proper handling. 2. Review, log and forward all emergency misdirected claims to the appropriate payer within ten days for receipt. 3. Monitor accurate handling of misdirected claims via monthly summary reports reviewed by the	1. HPSM_CAP_3.5.2_ Summary of Weekly Misdirected Claims Report Parameters HPSM_CAP_3.5.2_ Weekly_Report_Misdirected_Claims_Sample 2. HPSM_CAP_3.5.2_ Misdirected Claims Desk Procedure 3. HPSM_CAP_3.5.2_ Summary of Misdirected Emg	1. 3/31/14 2. 3/31/14 3. 1/1/15	The Plan did not forward misdirected claims to the appropriate provider prior to April 2014. The Plan would simply deny the claim and include forwarding information in the Remittance Advice. The Plan's claims system did not have the ability to detect misdirected claims when the billing Provider was not included as a payable provider in their claims system. <u>Recommendation</u> Forward misdirected claims to the appropriate Provider within 10 working days of receipt of the claim.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	Claims Director.	Claims 2015		The Plan developed a desktop procedure for misdirected claims and developed an automated report to monitor the handling of misdirected claims. The Claims Director will also receive a monthly summary report to ensure proper handling of misdirected claims. This item is closed
3.5.3 The Plan automatically reduced payment on Emergency Room (ER) claims without obtaining medical documentation	<p>1. At the time of review, HPSM did not deny claims for emergency services from non-contracted providers. HPSM's policy was to reduce the reimbursement amount to "the lowest level of emergency department evaluation and management CPT codes" as directed by COHS Contract AA.8.12D, when the claim lacked supporting documentation or a diagnosis that justified level 5 billing. Providers were notified of this via the RA and provided one year to submit additional information.</p> <p>This was in compliance with COHS contract A.8.12D which states: "At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for Physician services at the lowest level of emergency department evaluation and management CPT (Physician's Current Procedural Terminology) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services</p>	1. N/A	1. N/A	<p>3 of 25 claims that had payments reduced from Level 5 to the Level 1 rate. The Plan did not obtain any additional documentation from the billing Provider to support its reduction in payment from Level 5 to Level 1.</p> <p><u>Recommendation</u></p> <p>Pay claims with the CPT code 99285 at the proper rate</p> <p>The Plan changed its work process to pay 99285 claims in full without review for appropriateness. This item is closed</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>such as laboratory and radiology.” The three claims identified during the audit illustrate this process. All three claims were originally paid at the lowest level as there was no documentation or diagnosis to substantiate the 99385 level of service. In all three cases, the provider subsequently provided the documentation and the claims were adjusted to pay 99385 upon review by a clinician.</p> <p>2. Upon detailed review, Claims staff have evaluated the number of times that a provider has not substantiated level five and determined that it would be beneficial to the work processes of Plan staff and providers to change this process to pay these claims without review.</p> <p>3. ER claims billed with 99285 will be paid as billed and will not be reviewed for documentation or for appropriateness.</p>	<p>2. N/A</p> <p>3. HPSM_CAP_3.5.3_CO.02-01 Noncontracted Emergency Physician Services_Medi-Cal</p> <p>HPSM_CAP_3.5.3_ Request to MIS to pay 99285</p>	<p>2. July 2015</p> <p>3. July 2015</p>	

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
<p>3.5.4 The Plan did not process complete claims within 45 working days</p>	<p>1. Continue reimbursing clean claims within 45 days of receipt.</p> <p>2. HPSM to continue monitoring timely payment using the monthly DMHC Percent within 45 Days report.</p> <p>3. Overall HPSM has continued to reimburse over 99% of claims within 45 days as shown by the report included under #2. The audit included several claims that were originally processed incorrectly and therefore, aged back to the original claim receive date upon identifying the issue. To address quality issues such as this, a committee (3a) has been created that meets on a weekly basis comprised of Claims and MIS staff with the purpose of bringing forward system issues, identifying root cause, prevention and ensuring that all incorrectly processed claims are adjudicated with any applicable interest.</p> <p>3b. A Claims Quality Committee will also be added with the following purpose: -to ensure all identified claims related issues are disseminated to the appropriate staff. -Identify internal training needs.</p>	<p>1. N/A</p> <p>2. HPSM_CAP_3.5.4_DMHC_Percent within 45 Days June 2015</p> <p>3a . HPSM_CAP_3.5.4_Claims-MIS_Committee Log</p> <p>3b. HPSM_CAP_3.5.4_Claims Quality Committee Charter</p>	<p>1. On-going</p> <p>2. On-going</p> <p>3a. February 2014</p> <p>3b. October 2015</p>	<p>6 of 25 claims were paid or modified after 45 working days.</p> <p><u>Recommendation</u></p> <p>Process all claims within 45 working days.</p> <p>The Plan created the Claims Quality Committee to address quality issues regarding claims and other issues regarding claims. This item is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<ul style="list-style-type: none"> - Distribute new processes and protocol. - Report audit findings. - Develop and monitor the Claims audit plan. 			
<p>3.5.5 Remittance advices did not contain required denial reasons or identify follow-up information</p>	<p>1. Claim message 1500 is used to deny claims from providers who have not registered with State Medi-Cal. These providers can contact Provider Services with questions – Message updated to read, “INELIGIBLE PROVIDER-CONTACT PROVIDER SVCS”</p> <p>2. Process improvement for identifying new providers and tracking attempts to obtain required information updated. All related documents, including provider outreach, are saved for future reference.</p> <p>3 Logging of each “provider not found” record for future reference.</p> <p>4. Appeal/PDR language included on the last page of each RA.</p>	<p>1. HPSM_CAP_3.5.5_Claim Message Table</p> <p>2. HPSM_CAP_3.5.5_Provider Not Found_Flowchart</p> <p>HPSM_CAP_3.5.5_Provider Not on File_Desk Procedure</p> <p>3. HPSM_CAP_3.5.5_PNF Log</p> <p>4. HPSM_CAP_3.5.5_RA Appeal Info</p>	<p>1. March 2015</p> <p>2. May 2014</p> <p>3. May 2014</p> <p>4. April 2011</p>	<p>The Plan’s process did not disclose the specific denial rationale; instead it shifted the responsibility onto Providers to contact the Plan to discover the specific reason for denial in order to appeal the decision.</p> <p><u>Recommendation</u></p> <p>Disclose specific denial rationale. Ensure that when claims are denied, the reasons are appropriate. Effectively inform Providers of the Plan’s claims appeal process.</p> <p>Plan has submitted Claim message table, Provider Not Found (PNF) log, PNF flow chart, PNF adjudication and development desk procedure, a sample of payee statement of remittance appeal. This item is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
3.6.1 Remittance advices did not contain required denial reasons or identify follow-up information	<p>1. Appeal language continues to be included with each RA.</p> <p>2. Thorough review and validation of claim messages suppressed from HPSM's RAs to ensure that denial reasons are appropriately reported. 15 messages identified and corrected.</p> <p>3. Ensure that 2008 (lack of NDC number) is populated on the HSPM RA</p>	<p>1. HPSM_CAP_3.6.1_RA Appeal Info</p> <p>2. HPSM_CAP_3.6.1_HPSM ticket updating RA Messages</p> <p>3. HPSM_CAP_3.6.1_Sample RA with Message 2008</p>	<p>1. April 2011</p> <p>2. April 2015</p> <p>3. April, 2015</p>	<p>The Plan's process is to deny the claim and notify "Providers of its decision to pay or deny a claim via a weekly Remittance Advice (RA)" (HPSM 3.6.1 CO 02-02). Plan staff stated that this process informed Providers about how to follow-up on the decision. However, the Plan's process did not disclose the specific rationale; instead it shifted the responsibility onto Providers to contact the Plan to discover the specific reason for denial in order to appeal the decision.</p> <p><u>Recommendation</u></p> <p>Disclose specific denial rationale. Ensure that when claims are denied, the reasons are appropriate. Effectively inform Providers of the Plan's claims appeal process.</p> <p>Plan has submitted HPSM ticket to MIS for system updates regarding denial codes suppressed in error, sample of RA appeal info, sample of RA with message 2008. This item is closed.</p>
3.6.2 Systemic problems prevented the Plan from processing all claims within 45 working days	<p>1. Continue reimbursing clean claims within 45 days of receipt.</p> <p>2. HPSM to continue monitoring timely payment using the monthly DMHC Percent within 45 Days report.</p> <p>3. Overall HPSM has continued to reimburse over 99% of claims within 45 days as shown by the report</p>	<p>1. N/A</p> <p>2. HPSM_CAP_3.6.2_DMHC_Percent Within 45 Days_June 2015</p>	<p>1. On-going</p> <p>2. On-going</p>	<p>4 of 25 claims were paid or modified after 45 working days. All four claims did not meet the time requirement due to systemic issues with improper denials and inaccurate payment rates. Four of 25 claims were initially denied in error by a fault in the Plan's claims system. These four claims were only paid after the submitting Providers appealed the denial.</p>

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	<p>included. The audit sample included several claims that were originally processed incorrectly and therefore, aged back to the original claim receive date upon identifying the issue.</p> <p>3a. To address quality issues such as this, a committee has been created that meets on a weekly basis comprised of Claims and MIS staff with the purpose of bringing forward system issues, identifying root cause, prevention and ensuring that all incorrectly processed claims are adjudicated with any applicable interest.</p> <p>3b. A Claims Quality Committee will also be added with the following purpose: -to ensure all identified claims related issues are disseminated to the appropriate staff. -Identify internal training needs. - Distribute new processes and protocol. - Report audit findings. - Develop and monitor the Claims audit plan.</p>	<p>3a. HPSM_CAP_3.6.2_ Claims-MIS_Log</p> <p>3b. HPSM_CAP_3.6.2_ Claims Quality Committee Charter</p>	<p>3a. February 2014</p> <p>3b. October 2015</p>	<p><u>Recommendation</u></p> <p>Process all claims within 45 working days.</p> <p>Plan has submitted Claims Quality Committee chart, Claims MIS log, log for percent paid within 45 days. This item is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
3.7.1 The Plan did not monitor Emergency Departments to ensure Members have access to a 72-hour supply of drugs in emergency situations	<ol style="list-style-type: none"> Review existing policy on Oversight of EDs Perform review of identified contracted emergency rooms annually 	<ol style="list-style-type: none"> HPSM_CAP_3.7.1_HS-11 Oversight of ED Dispensing of Drugs HPSM_CAP_3.7.1_Review of ERs and drug access <p>HPSM_CAP_3.7.1_2015 Hospital ER Pharm</p> <p>HPSM_CAP_3.7.1_Review of ERs and Drug Access</p>	<ol style="list-style-type: none"> July 2015 To be completed August 2015 	<p><u>Recommendation</u></p> <p>Ensure all contracted Emergency Departments have policies and procedures that outline emergency medication dispensing as required by the Plan's policy and the Contract. Monitor Emergency Departments to ensure provision of prescribed drugs dispensed in emergency situations as specified in Plan policy.</p> <p>The Plan submitted an example of annual review form for the dispensing of emergency drug by EDs. This item is provisionally closed. Please send completed evaluation form when completed.</p> <p>10-23-15</p> <p>The Plan submitted its annual review of ERs and drug access. This item is closed.</p>
3.7.2 The Pharmacy and Therapeutics Committee did not review and update formulary at the required frequency	<ol style="list-style-type: none"> Comply with plan's contract and policy of holding P&T meetings six times per year (or no less than quarterly basis). 	<ol style="list-style-type: none"> HPSM_CAP_3.7.2_P&T Cmte Pkt_NOV 2014 HPSM_CAP_3.7.2_P&T Cmte Pkt_JAN 2015 HPSM_CAP_3.7.2_P&T Cmte Pkt_MAR 2015 HPSM_CAP_3.7.2_ 	<ol style="list-style-type: none"> Completed. HPSM has already hosted 5 P&T meetings by 7/8/15 (since Nov 2014). September and November 2015 	<p>According to P&T minutes the Plan had only three P&T Committee meetings during the audit period. The P&T Committee did not meet as frequently as required by the Contract, nor as indicated in Plan policy.</p> <p><u>Recommendation</u></p> <p>Ensure Pharmacy & Therapeutics (P&T) Committee meets to review and update formulary in accordance with the frequency requirements.</p>

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		P&T Cmte Pkt_MAY 2015 HPSM_CAP_3.7.2_P&T Cmte Pkt_JUL 2015	meetings still scheduled	The Plan submitted agendas from five P&T Committee meetings held in seven months showing that the formulary was reviewed and updated each time. This item is closed.
4. Members' Rights				
4.1.1 Improper identification and reporting of grievances	<p>Proper Identification of Complaints:</p> <p>1. Created a job-aide to assist Member Services staff with the proper identification and handling of member calls involving complaints.</p> <p>2. Conducted a series of trainings for the Member Services staff on how to identify a grievance and how such cases should be handled. The new job-aide was covered in these trainings.</p>	<p>1. HPSM_CAP_4.1.1_1_Mbr Serv Cue Cards_5.12.15</p> <p>2. HPSM_CAP_4.1.1_2_Mbr Serv Cue Cards Training_Sign In Sheet_05.12.15</p> <p>HPSM_CAP_4.1.1_2_Mbr Serv Cue Cards_05.12.15</p> <p>HPSM_CAP_4.1.1_2_Mbr Serv General Training_Minutes_6.13.14</p> <p>HPSM_CAP_4.1.1_2_Mbr Serv General Training_Presentation_06.13.14</p> <p>HPSM_CAP_4.1.1_2_</p>	<p>1. 5/12/15</p> <p>2. 06/13/2014; 02/13/2015; 05/12/2015; 06/12/2015</p>	<p>The Plan's grievance system did not capture all complaints and expressions of dissatisfaction regarding the Plan and Providers.</p> <p>The inquiry call log had 154 instances in which Members were "upset" but these were not classified as grievances.</p> <p><u>Recommendation</u></p> <p>Capture all complaints and expressions of dissatisfaction, including those where a Member declined to file a grievance and where a Member did not explicitly state that they would "like to file a grievance". Implement a functioning grievance system.</p> <p>The Plan submitted multiple examples of training materials provided too HPSM staff regarding identifying and reporting grievances. The Plan also submitted a Report of Calls coded with M14. This item is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>3. Conducted trainings with the following departments on how to identify a grievance or appeal and how to forward the issue to the Grievance and Appeals Unit: California Children's Services; Health</p>	<p>Mbr Serv General Training_Sign n Sheet_06.13.14</p> <p>HPSM_CAP_4.1.1_2_Mbr Serv Scenario Training_Call Recording Script_6.12.15</p> <p>HPSM_CAP_4.1.1_2_Mbr Serv Scenario Training Worksheet_06.12.15</p> <p>HPSM_CAP_4.1.1_2_Mbr Serv Scenario Training Mtg Minutes_06.12.15</p> <p>HPSM_CAP_4.1.1_2_Mbr Serv Writing Comments Training Minutes_2.13.15</p> <p>HPSM_CAP_4.1.1_2_Mbr Serv Writing Comments Training Presentation_2.13.15</p> <p>3. HPSM_CAP_4.1.1_3_Care Coord Training Presentation_06.25.15</p>	<p>3. 06/25/15 (CCS); 03/18/2015 (Health Services Dept); 04/15/15</p>	

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>Services Dept.; Quality Dept.; Pharmacy Unit.; Marketing Dept.; Care Coordination Dept.; Compliance Dept.;</p>	<p>HPSM_CAP_4.1.1_3_Care Coord Training Sign in Sheet_06.25.15</p> <p>HPSM_CAP_4.1.1_3_CCS Training Presentation_06.25.14</p> <p>HPSM_CAP_4.1.1_CCS Training Sign in Sheet_06.25.14</p> <p>HPSM_CAO_4.1.1_3_Health Serv Training_Presentation_03.18.15</p> <p>HPSM_CAP_4.1.1_3_Health Serv Training_Sign in Sheet_03.18.15</p> <p>HPSM_CAP_4.1.1_3_Marketing Training Presentation_06.01.15</p> <p>HPSM_CAP_4.1.1_3_Marketing Training Sign In Sheet_06.01.15</p> <p>HPSM_CAP_4.1.1_3_Pharmacy Training Presentation_04.15.15</p>	<p>(Pharmacy Unit); 05/05/15 (Quality Dept) 06/01/2015 (Marketing Dept); 06/25/15 (Care Coordination Unit & Compliance Dept).</p>	

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>Identification of Grievances Related to a PCP Change:</p> <p>4. Reviewed all PCP changes reported to DHCS during the audit period and determined that only 37% of these PCP changes had the possibility of being related to member dissatisfaction. The other 63% were related to other issues unrelated to dissatisfaction, such as providers leaving the Plan or Members wanting the same PCP as a family member.</p> <p>5. Implemented change in procedure for handling PCP change requests, which incorporates the grievance process. Trained Member Services staff on this procedure change.</p>	<p>HPSM_CAP_4.1.1_3_ Pharmacy Training Sign in Sheet_04.15.15</p> <p>HPSM_CAP_4.1.1_3_ Quality Training Presentation_05.05.15</p> <p>HPSM_CAP_4.1.1_3_ Quality Training Sign in Sheet_05.05.15</p> <p>4. HPSM_CAP_4.1.1_4_ Review of PCP Changes During DHCS Audit Period 2014</p> <p>5. HPSM_CAP_4.1.1_5_ List of PCP Change Code Reasons</p> <p>HPSM_CAP_4.1.1_5_ Sign in Sheet for Training on PCP Change Code</p>	<p>4. 03/15/15</p> <p>5. 05/12/15</p>	

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>6. Plan will include PCP change data in quarterly report presented to the Consumer Advisory Committee and Quality Assessment and Improvement Committee, both of which report to the San Mateo Health Commission and have representation by Commissioners.</p> <p>Review of Call Logs to Identify Possible Grievances:</p> <p>7. Created a new report of all calls in which a member is offered to file a grievance but declines. Member Services Manager conducts daily review of this report.</p>	<p>Reasons</p> <p>6. HPSM_CAP_4.1.1_6_ Email Re Quarterly Reporting for PCP Change Data 6.29.15</p> <p>HPSM_CAP_4.1.1_6_ Ticket to MIS Reporting Team for New Report on PCP Changes</p> <p>7. HPSM_CAP_4.1.1_7_ Email from Member Serv Manager re M14 Review Process</p> <p>HPSM_CAP_4.1.1_7_ Report of Calls Coded as M14_07.08.15</p>	<p>6. Estimated completion date 08/19/15 (QAIC Mtg date)</p> <p>7. 6/29/15; Ongoing</p>	
4.1.2 Lack of clinical oversight on grievance classification	<p>1. Hired a Registered Nurse to review all grievances and determine which grievances require additional clinical review for quality of care concerns.</p> <p>2. Amended grievance intake process such that all grievances are reviewed by the Quality Review Nurse prior to being assigned to a Grievance and Appeals Coordinator.</p>	<p>1. HPSM_CAP_4.1.2_ Position Change Request and Budget Summary for HS_2015</p> <p>2. HPSM_CAP_4.1.2_ G&A Staff Meeting Minutes_04.20.15</p>	<p>1. Hire date 04/13/15</p> <p>2. 04/20/15</p>	<p>No oversight was conducted by clinical personnel to ensure proper identification of clinical/quality of care grievances.</p> <p><u>Recommendation</u></p> <p>Develop and implement a process for monitoring and reviewing grievances designated as non-clinical to ensure quality of care issues are not missed.</p>

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	3. Update Policy and Procedure to reflect the amended intake process.	3. N/A – Not yet Completed HPSM_CAP_4.1.2_G A-07_Grievance Process_NonMedicare LOBs	3. Estimated completion 10/01/2015	<p>The Plan hired a registered nurse to review all grievances for the following:</p> <ul style="list-style-type: none"> a. Expedited vs. Standard Timeframe (if requested by member) b. Need for additional clinical review (i.e. QOC or appeal) c. Need for clarification or additional information to conduct clinical review (i.e. Specific medical records; clarification about the member's complaint, etc.) d. Type of Service <p>The new intake process was modified to ensure that all grievances are reviewed by the Quality Review nurse.</p> <p>This item is provisionally closed. Please provide updated P&Ps that reflect the amended intake process when available.</p> <p>10-23-15</p> <p>The Plan submitted its updated policy GA-07 that contains the amended intake process. This item is closed.</p>
4.1.3 Time frames exceeded for grievance notification and resolution	<u>Timeliness of Acknowledgment Letters:</u> 1. Administrative Assistant hired for Grievance and Appeals Unit to assist with clerical duties	1. HPSM_CAP_4.1.3_Summary of Position Changes_2015 Salary Budget	1. Hire date 02/02/15	A total of 80 grievance files were reviewed. Eight acknowledgment letters were not sent within the five calendar day time frame. 24 grievances were not resolved and did not have resolution letters sent to the Member within 30 calendar days. Nine grievances were resolved over 60 days

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	<p>previously performed by G&A Coordinators, which included the writing and mailing of acknowledgment letters.</p> <p>2. Conducted a root cause analysis to determine the reason for late acknowledgment letters. Identified weaknesses and inefficiencies in the process. Instituted new process for tracking outstanding acknowledgment letters and discussed new tracking process with staff.</p> <p>3. Created daily report of outstanding acknowledgment letters to ensure that all letters are sent timely. This report is reviewed daily by the Administrative Assistant, who is responsible for mailing acknowledgment letters.</p> <p><u>Timeliness of Resolution Letters:</u></p> <p>4. Additional Grievance and Appeals (G&A) Coordinator hired to</p>	<p>HPSM_CAP_4.1.3_ Position Change Request Form for G&A_2015</p> <p>2. HPSM_CAP_4.1.3_ Email to G&A Admin Asst_07.01.15</p> <p>3. HPSM_CAP_4.1.3_ Report_GA_ Outstanding Ack Letters_07.01.15</p> <p>4. HPSM_CAP_4.1.3_ Summary of Position Changes_2015 Salary</p>	<p>2. 07/01/15</p> <p>3. 07/01/15</p> <p>4. Hire date 02/02/15</p>	<p>after receipt.</p> <p><u>Recommendation</u></p> <p>Send grievance acknowledgment letters to Members within the five calendar days and resolution letters within 30 calendar days. Resolve grievances within 30 calendar days.</p> <p>The Plan hired a registered nurse, administrative assistant and an additional grievance and appeals coordinator to assist with the processing of member grievances. A new process for tracking outstanding acknowledgement letters was established. Daily monitoring reports for acknowledgement letters and weekly timelines reports are being reviewed by the G&A manager. This item is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>decrease Coordinator caseload</p> <p>5. Weekly timeliness report reviewed by G&A Manager and shared with G&A staff.</p> <p>6. Confirmation of timely closure of Medi-Cal 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>Budget</p> <p>HPSM_CAP_4.1.3_ Position Change Request Form for G&A_2015</p> <p>5. Materials from first report and most recent:</p> <p>HPSM_CAP_4.1.3_ Staff Mtg Agenda_08.03.14</p> <p>HPSM_CAP_4.1.3_ Staff Mtg Sign in Sheet_08.03.14</p> <p>HPSM_CAP_4.1.3_ Staff Mtg Agenda_06.22.15</p> <p>HPSM_CAP_4.1.3_ Staff Mtg Sign in Sheet_06.22.15</p> <p>6. HPSM_CAP_4.1.3_ Report of MC Grievances Closed 05.01.15-06.30.15</p>	<p>5. Begun 08/03/14, ongoing</p> <p>6. Report run 06/30/15</p>	

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<p>4.1.4 Grievance status notification letters not sent to Members when a resolution was not reached within 30 days</p>	<p>1. Additional Grievance and Appeals (G&A) Coordinator hired to decrease Coordinator caseload</p> <p>2. Report run to confirm timeliness of extension letters.</p>	<p>1. HPSM_CAP_4.1.4_Summary of Position Changes_2015 Salary Budget</p> <p>HPSM_CAP_4.1.4_Position Change Request Form for G&A_2015</p> <p>2. HPSM_CAP_4.1.4_Report_Timeliness of Grievance Extension Letters</p>	<p>1. Hire date 02/02/15</p> <p>2. 07/01/15</p>	<p>The Plan did not send notification letters to Members when a resolution was not reached within 30 days. 21 of 24 grievances processed beyond the 30 calendar day time frame did not have a status notification letter with an estimated completion date of resolution.</p> <p><u>Recommendation</u></p> <p>Send a written notice of the status of the grievance and estimated completion date of resolution to Members when a resolution is not reached within 30 days.</p> <p>The Plan hired a registered nurse, administrative assistant and an additional grievance and appeals coordinator to assist with the processing of member grievances. A new process for tracking outstanding acknowledgement letters was established. Daily monitoring reports for acknowledgement letters and weekly timelines reports are being reviewed by the G&A manager. This item is closed.</p>

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4.1.5 Time frames exceeded for expedited grievance resolution	<ol style="list-style-type: none"> Additional Grievance and Appeals (G&A) Coordinator hired to decrease Coordinator caseload Report run to confirm timeliness of expedited grievance resolution. 	<ol style="list-style-type: none"> HPSM_CAP_4.1.5_Summary of Position Changes_2015 Salary Budget HPSM_CAP_4.1.5_Position Change Request Form for G&A_2015 HPSM_CAP_4.1.5_Report_Timeliness of Expedited Grievance Resolution 	<ol style="list-style-type: none"> Hire date 02/02/15 07/01/15 	<p>Two of seven expedited grievances were not processed within three calendar days.</p> <p><u>Recommendation</u></p> <p>Send expedited grievance acknowledgment and resolution letters to Members within the required time frames.</p> <p>The Plan hired an additional G&A coordinator to decrease coordinator case load. The Plan also submitted a report which shows that the Plan sent out extension notices to members if the grievance went beyond 30 days. This item is closed</p>
4.1.6 Acknowledgment and resolution letters not translated to the Plan's threshold language	<ol style="list-style-type: none"> On September 9, 2014, the applicable policy, <i>GA-07 Member Grievance Procedure for Non-Medicare Lines of Business (Section 9.11)</i> was updated to include specific guidance regarding the translation of all member grievance letters into a member's preferred language. In order to track the Grievance and Appeals (G&A) Unit's implementation of this requirement, a new data field was created in the G&A System, Everest, to indicate that a translated letter is required. This new data field was discussed with G&A staff at a 	<ol style="list-style-type: none"> HPSM_CAP_4.1.6_GA-07_Grievance Process_NonMedicare LOBs (section 9.1) HPSM_CAP_4.1.6_G&A Staff Mtg Minutes_04.20.15 	<ol style="list-style-type: none"> 09/9/14 04/20/15 	<p>Fifteen of 80 grievance files reviewed were for Members with a preferred language other than English. Fourteen of 15 acknowledgment letters were not translated to the Plan's threshold language. Eleven of 15 resolution letters were not translated to the Plan's threshold language.</p> <p><u>Recommendation</u></p> <p>Send acknowledgment and resolution letters to Members that are fully translated to the Plan's threshold language.</p> <p>The Plan modified its P&P to include language on the translation of grievance letters. A new</p>

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	<p>staff meeting on April 20, 2015.</p> <p>3. Report comparing a member's preferred language, as indicated on his/her eligibility file, to the language of his/her grievance letters confirms that all members with a preferred language other than English have received translated letters. The report included grievances received between 04/1/2015 and 07/10/2015.</p>	<p>3. HPSM_CAP_4.1.6_Report of Translated Letters_Grievances_07.10.15</p>	<p>3. 07/10/15</p>	<p>data field was included in the G&A system to indicate that a translated letter is required. This item is closed</p>
<p>4.1.7 Grievance resolution did not address all complaints or did not appropriately address the complaint</p>	<p>1. Distributed policy change memo to Grievance and Appeals staff indicating that resolution letters must address all issues raised in a grievance. Discussed the memo with Grievance and Appeals staff during staff meeting.</p> <p>2. Updated policy <i>GA-07 Member Grievance Procedure for Non-Medicare Lines of Business</i> to indicate that all issues presented in a grievance must be addressed in the member resolution letter (<i>Section 7.2</i>) and that a case may not be closed until all issues in the grievance have been fully resolved (<i>Section 9.7</i>). In addition, Section 18.8 of this policy was updated to indicate that all resolution letters are</p>	<p>1. HPSM_CAP_4.1.7_Policy Change Memo_06.20.14</p> <p>HPSM_CAP_4.1.7_Staff Mtg Sign In_06.20.14</p> <p>2. HPSM_CAP_4.1.7_GA-07_Grievance Process NonMedicare LOBs</p> <p>HPSM_CAP_4.1.7_Case Example_Resolution Letter</p> <p>HPSM_CAP_4.1.7_Case Example_Complaint Summary</p>	<p>1. 06/20/14</p> <p>2. 09/09/15</p>	<p>Resolution letters sent to Members did not address the issue or all of the issues raised in the grievances and responses were not clear and concise. Case records did not consistently show an investigation by the Grievance Coordinator to find the root cause of the problem and an explanation for the issue was not given to the Member. Problems with Providers and complaints about access to services were resolved in many instances simply by changing PCP. Many resolution letters contained improper responses to the Members' complaints.</p> <p><u>Recommendation</u></p> <p>Send Members resolution letters that are clear and concise, address all issues raised in the grievance and have responses that are appropriate and in compliance with the Contract and applicable regulations and policies.</p> <p>The Plan updated its policy to state that all issues presented in a grievance must be</p>

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	<p>reviewed by the Grievance and Appeals Manager prior to submission to the member. Part of this review includes an assessment of whether the letter fully addresses each issue raised by the member.</p> <p>3. Manager and Senior Communications Specialist conducted training for G&A Coordinators responsible for writing Member and provider letters. Training focused on communicating clearly through writing at a 6th grade level. This included a discussion of how to organize a resolution letter that includes multiple issues, in order to ensure the letter has adequately addressed each issue.</p>	<p>3. HPSM_CAP_4.1.7_ Writing Training Materials_02.20.15</p> <p>HPSM_CAP_4.1.7_ Sign In Sheet Writing Training_02.20.15</p> <p>HPSM_CAP_4.1.7_ Sign In Sheet_ Writing Follow up Training_03.25.15</p>	<p>3. 2/20/15</p>	<p>addressed and that the case cannot be closed until all elements in the grievance are addressed. The policy was also updated to ensure the G&A manager reviews all issues are addressed in the resolution letters before they are sent to the member. A training was conducted which focused on communicating clearly at a sixth grade level and adequately addressing all issues in a grievance letter. This item is closed.</p>
<p>4.1.8 The Plan did not specify whether resolved grievances were in favor of the Member or the Plan</p>	<p>1. Define grievance resolution categories: As addressed by DHCS in a webinar held 5/08/15 and in a follow-up email sent to Plans on 05/14/2015, many grievances are not easily categorized as being either in favor of the Member or the Plan. For this reason, DHCS suggested</p>	<p>1. HPSM_CAP_4.1.8_ Webinar Invitation from DHCS_05.08.15</p> <p>HPSM_CAP_4.1.8_ Follow Up Email from DHCS re Grievance Resolution</p>	<p>1. 07/10/15</p>	<p><u>Recommendation:</u></p> <p>Determine whether grievances classified as “favorable” are classified in favor of the Member or the Plan. Consistently apply that terminology.</p> <p>The Plan will define grievance resolution</p>

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	<p>creating a third category to indicate grievances in which, “a member’s opinion differs with the plan/provider for subjective/gray area issues.” In addition, the plan also sees the need for a fourth category for cases involving possible quality of care issues. For complaints related to quality of care, the Grievance and Appeals Unit does not determine whether the member’s complaint was valid, as this is a clinical judgment made by the Medical Director or designee within the Quality Department, independent of the grievance process. Therefore, in accordance with DHCS’ suggestion, the Plan will create the following grievance resolution categories. The Plan has used DHCS’ definitions for the first two categories, as provided in the email on 5/14/2015:</p> <p>a) Closed/Validated (i.e. “in favor of the member”) is defined as meaning that after examination of the member’s complaint, the plan determined that indeed there was an issue which validated the member’s complaint, therefore the plan took steps to remedy the member’s concern.</p> <p>b) Closed/Unfounded (i.e. in favor of</p>	Categories_5.14.15		categories as addressed by DHCS in the Webinar held 5-8-15 and in the follow-up sent on 5-14-15. The new categories and definitions are reflected in the updated GA-07 submitted on 10-23-15. This item is closed.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>the plan) is defined as meaning that after examination of the member's complaint, the plan disagreed with the member's complaint as the plan's research showed the issue to be unsubstantiated.</p> <p>c) Closed/Unable to Confirm is defined as meaning that after examination of the member's complaint, the plan was unable to determine whether the member's complaint was valid because the complaint was subjective in nature or because the member's account differed from that of the plan or provider and the plan was unable to confirm the validity of either position.</p> <p>d) Closed/ QOC is defined as meaning that the complaint involved a possible quality of care issue and was forwarded to the Quality Department for clinical review.</p> <p>2. Implement new resolution categories in G&A tracking system: HPSM is implementing a new electronic tracking system for grievances and appeals (i.e. MedHOK), scheduled to go live 10/01/2015. The categories above will be included as the available categorization options in this new</p>	<p>2. N/A To be Completed</p>	<p>2. Estimated completion date 10/01/15</p>	

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>system.</p> <p>3. Train staff on new categories and definitions: Staff training will be included as part of the implementation process for the Plan's new electronic tracking system (MedHOK)</p> <p>4. Update policy to reflect new categories and definitions</p>	<p>3. N/A To be Completed</p> <p>4. N/A To be Completed</p>	<p>3. Estimated completion date 10/01/15</p> <p>4. Estimated completion date 10/01/15</p>	
<p>4.1.9 Grievance data was not reported, tracked or appropriately monitored</p>	<p>1. Grievance and Appeals reporting is a standing agenda item on the HPSM Consumer Advisory Committee (CAC) agenda and has been since 2007. The Consumer Advisory Committee is a sub-committee of the San Mateo Health Commission.</p> <p>2. Two Commissioners of the San Mateo Health Commission serve on the Consumer Advisory Committee. HPSM's CEO, CMO, Deputy CMO, and Director of Member Services and Outreach are also present for each Consumer Advisory Committee meeting.</p> <p>3. Minutes of the Consumer Advisory Committee are included in the agenda packets of the San</p>	<p>1. HPSM_CAP_4.1.9_CAC Meeting Minutes (folder)</p> <p>HPSM_CAP_4.1.9_Consumer Advisory Committee Reports (folder)</p> <p>2. HPSM_CAP_4.1.9_CAC Meeting Minutes (folder)</p> <p>HPSM_CAP_4.1.9_SMHC Commission Meeting Agendas (folder)</p> <p>3. HPSM_CAP_4.1.9_SMHC Commission Meeting Agendas</p>	<p>1. Quarterly reporting to the CAC since 2007. Quarterly reporting will continue.</p> <p>2. Quarterly reporting since 2007. Quarterly reporting will continue.</p> <p>3. G&A report was first presented</p>	<p>The meeting minutes for the Quality Assessment and Improvement Committee (QAIC) did not contain any records of grievances reviewed during the audit period. The Staff Grievance and Appeals Committee (SGAC) had minutes for only seven of 23 meetings during the audit period. The minutes did not contain the names of the committee members attending. Minutes for March 24, 2014 stated that the committee would look at complex grievance cases only going forward, as opposed to review of all pending grievances. The Quality Management Oversight Committee (QMOC) did not have any meeting minutes for the audit period and was disbanded in December 2013. The San Mateo Health Commission (SMHC) did not review any grievance records other than through the Consumer Advisory Committee minutes in the consent agenda.</p> <p>There was no evidence that grievance data related to various departments of the Plan (cultural and linguistic, pharmacy and access)</p>

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	<p>Mateo Health Commission as a Consent Item. Any item on the Consent Agenda can be moved to the regular agenda at the request of a Commissioner.</p> <p>4. The Grievance and Appeals Report presented to the Consumer Advisory Committee are now presented to the Quality Assessment and Improvement Committee (QAIC) as well, which is also a sub-committee of the San Mateo Health Commission.</p>	<p>(folder)</p> <p>4. HPSM_CAP_4.1.9_QAIC Meeting Agenda_Minutes (folder)</p>	<p>to QAIC on 3/26/15. Quarterly reporting will continue.</p>	<p>was communicated to those departments to ensure appropriate corrective action and to ensure that this data was used as part of a Plan Quality Improvement System.</p> <p><u>Recommendation</u></p> <p>Submit grievance records to the Quality Assurance Committee for review on a quarterly basis. Document SGAC meetings and list the names of attendees. Ensure that the Plan's policy for grievance monitoring and record submission reflects and is consistent with the Plan's actual process in place. Communicate grievance data to the appropriate departments at the Plan. Use grievance data for Quality Improvement.</p> <p>The Plan submitted multiple examples of CAC summaries and CAC Grievance and Appeals reports showing that grievances are reviewed. Minutes from the QAIC were also submitted showing that Grievance and Appeals Report was presented. This item is closed.</p>
<p>4.1.10 The Plan did not have a grievance form</p>	<p>1. Create Member Grievance Form and submit to the Department of Managed Health Care for approval</p>	<p>1. HPSM_CAP_4.1.10_Member Grievance Form_Draft</p> <p>HPSM_CAP_4.1.10_Exhibit E-1_Filing Summary_20151514</p> <p>HPSM_CAP_4.1.10_</p>	<p>1. 6/16/15</p>	<p>The Plan did not have forms at each facility of the Plan, on the Plan's website, or at each contracting Provider's facility. Members needing to file a grievance in writing were required to write a statement on their own and fax it or deliver it to the Plan.</p> <p><u>Recommendation</u></p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	2. Work with Provider Services staff to distribute Member Grievance Form to all contracted provider offices and facilities.	Confirmation of DMHC Filing_Mbr Grievance Form 2. N/A – To be completed	2. Estimated completion date 12/01/15	Develop and provide grievance forms to Members upon request and have them available at each facility of the Plan, on the Plan's website and at each contracting Provider's site. The Plan developed a draft of grievance form and submitted it to DMHC for approval. The form is available for download from the website. This item is closed.
4.1.11 The Plan's policy did not reflect the actual grievance process	1. Update all Grievance and Appeals policies to reflect current process. This includes: a) GA-01 – Grievance and Appeals Definitions – General b) GA-07- Member Grievance Procedure for Non- Medicare Lines of Business c) GA-08 – Member Appeals Procedure for Non-Medicare Lines of Business	1. N/A – To be completed HPSM_CAP_4.1.11_GA-07_Grievance Process_NonMedicare LOBs	1. Estimated completion date 10/01/2015	Although the Plan had a policy and procedure for the grievance system (Policy#: GA-07, Member Grievance Procedure for Non-Medicare Lines of Business), it did not reflect the actual grievance process <u>Recommendation</u> Ensure that the Plan's grievance policy reflects and is consistent with the Plan's actual grievance process. The Plan will update its grievance and appeals policy to reflect current process. This item is provisionally closed. Please submit updated procedure when completed. 10-23-15 The Plan submitted its updated policy GA-07. This item is closed.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
4.1.12 Lack of grievance and appeal system oversight by the designated Plan Grievance Officer	<ol style="list-style-type: none"> 1. 7/22/2014: HPSM CEO announces that Director, Member Services and Outreach is responsible for Grievance and Appeals 2. Director, Member Services and Outreach attends Grievance and Appeals Staff meetings 3. Director, Member Services and Outreach attends Staff Grievance and Appeals Committee meetings 4. Director, Member Services and Outreach meets weekly with the Grievance and Appeals Manager to review projects, activities, and objectives. They also meet on an ad-hoc basis as issues arise. 	<ol style="list-style-type: none"> 1. HPSM_CAP_4.1.12_Organizational Changes 2. HPSM_CAP_4.1.12_Staff Mtg Sign In Sheet_07.28.14 HPSM_CAP_4.1.12_Staff Mtg Sign In Sheet_06.22.15 3. HPSM_CAP_4.1.12_SGAC_Sign In Sheet_07.28.14 HPSM_CAP_4.1.12_SGAC_Sign In Sheet_06.22.15 4. HPSM_CAP_4.1.12_Documentation of Weekly Meetings 	<ol style="list-style-type: none"> 1. Effective 7/22/2014 2. Effective 07/28/2014 3. Effective 07/28/2014 4. Ongoing 	<p>Based on the review of Plan documents and interviews with Plan personnel, there was no continuous review of the operation of the grievance system and no identification or consideration of these problems by a designated Grievance Plan Officer.</p> <p><u>Recommendation</u></p> <p>Require the designated Plan Grievance Officer to continuously review the operation of the grievance system in order to identify any emergent patterns of grievances.</p> <p>The Plan announced that the Director of Member Services and Outreach is responsible for Grievances and Appeals. The Plan provided evidence that the Member Services and Outreach Director attended multiple G&A staff and committee meetings. The Director of Member Services and Outreach meets regularly with the Grievance and Appeals Manager on an ongoing basis. This item is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
4.2.1 Lack of access to interpreter services	<ol style="list-style-type: none"> 1. Update policy and procedure on standard practice for all Cultural and linguistic grievances. 2. Notification process 24-72 after filing to assure member has received adequate interpreter services. 3. Annually include information in member newsletter and provider newsletter on access to interpreter services. 4. Train all new hires on C&L services and document attendance. 5. Provider services will train all new providers during orientation on accessing interpreter services and all existing provider during outreach attempts. 6. Distribute provider toolkit during 	<ol style="list-style-type: none"> 1. HPSM_CAP_4.2.1_QAI CL-01 Cultural and Linguistic Services 2. HPSM_CAP_4.2.1_QAI CL-01 Cultural and Linguistic Services HPSM_CAP_4.2.1_Summary Dashboard Grievances 3. N/A To be completed 4. HPSM_CAP_4.2.1_C&L Training HPSM_CAP_4.2.1_C&L Training Attestation 5. HPSM_CAP_4.2.1_C&L Training HPSM_CAP_4.2.1_C&L Training Attestation 6. HPSM_CAP_4.2.1_ 	<ol style="list-style-type: none"> 1. June 2015 2. June 2015 3. Fall 2015 4. July 2015 5. Started June 2015 and ongoing 6. Started June 2015 	<p>An example was found in a grievance where a delegated entity did not provide interpreter services. The Plan resolved the problem by issuing a resolution letter the next time the delegated entity confirmed that the Member had received interpreter services. However, the Plan did not follow-up on the problem to ensure that the Member would always receive interpreter services at all key points of contact. The Cultural and Linguistic (C&L) staff had no knowledge of the grievance. There was no effective communication between C&L and the grievance department. The Plan did not have a method to ensure access to interpreter services at all key points of contact. The Plan did not demonstrate oversight over its delegated entity.</p> <p><u>Recommendation</u></p> <p>Provide 24 hour oral-interpreter services at all key points of contact.</p> <p>The Plan updated its Policy to ensure the Quality Department is notified of C&L grievances. Training for internal staff and provider staff on accessing interpreter services is being conducted. Annual consumer survey contains questions on interpreter services. This item is closed</p>

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	<p>triennial facility site review credentialing visits.</p> <p>7. Conduct annual consumer satisfaction survey.</p> <p>8. Distributed interpreter service to Behavior Health Services.</p> <p>9. Run quarterly list of PCP that see Non-English members and compare to interpreters utilization and analyzes for appropriate use. Review reports with Medical Director and Health Inequities Group.</p>	<p>Provider Toolkit</p> <p>7. HPSM_CAP_4.2.1_Consumer Satisfaction Survey-Adult</p> <p>HPSM_CAP_4.2.1_Consumer Satisfaction Survey-Children</p> <p>8. HPSM_CAP_4.2.1_Provider Toolkit</p> <p>9. HPSM_CAP_4.2.1_Quarterly Provider Telephonic Interpretation Usage_Sample</p>	<p>and ongoing</p> <p>7. Fall 2015</p> <p>8. June 2015</p> <p>9. Q3 2015</p>	

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4.2.2 Translated material not accessible through the Plan's website	1. Created a one page link on the website in different threshold languages (Chinese, Spanish and Tagalog) that members can access to learn about member material, newsletter, and contact to Medical or COB.	1. HPSM_CAP_4.2.2_HPSM Website Member – Chinese HPSM_CAP_4.2.2_HPSM Website Member – Spanish HPSM_CAP_4.2.2_HPSM Website Member - Tagalog	1. April 2015	Although the Plan's website contained documents translated into Spanish, these were inaccessible to Members who were not proficient in English. An English-only website created a barrier and did not ensure equal access to health care services and health education. <u>Recommendation</u> Translate the Plan's website to the threshold language. The Plan translated its webpage into Spanish, Tagalog and Chinese. This item is closed.
4.2.3 The Plan did not use GNA findings to influence C&L initiatives	1. Review and use GNA findings to plan C&L initiatives for 2015 work plan. 2. Present annual GNA updates to the Quality Improvement Committee and health inequities group.	1. HPSM_CAP_4.2.3_Cultural and Linguistics Work Plan 2015 2. HPSM_CAP_4.2.3_Health Inequities Grp Minutes_3.6.15 HPSM_CAP_4.2.3_Health Inequities Grp Minutes_4.24.15 HPSM_CAP_4.2.3_Health Inequities Grp Minutes_5.13.15 HPSM_CAP_4.2.3_	1. April 2015 2. Completed March 2015 and ongoing	The Plan did not utilize findings from the 2011 GNA to guide initiatives for C&L improvement. <u>Recommendation</u> Use the GNA survey findings to guide initiatives of the C&L Committee. The Plan submitted their 2015 C&L Work Plan. The Work states that the GNA findings will be reviewed to reduce member health disparities among ethnic/racial groups. Annual GNA updates are to be presented at the QIC and the health inequities group. This item is closed.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
		Health Inequities Grp Minutes_6.12.15		
4.2.4 C&L Committee did not implement initiatives based on the QI Work Plan	<p>1. C&L Committee meeting and discussing initiatives based on QI work plan.</p> <p>2. Presentation on pertinent GNA/Work plan topics reporting on C/L activities related to QI work plan. Demographic data on Cervical Cancer Screening was analyzed by the Quality Support Analysis and Quality Specialist. The demographic data was</p>	<p>1. HPSM_CAP_4.2.4_QI WORKPLAN 2015</p> <p>HPSM_CAP_4.2.4_Health Inequities Grp Minutes_3.6.15</p> <p>HPSM_CAP_4.2.4_Health Inequities Grp Minutes_4.24.15</p> <p>HPSM_CAP_4.2.4_Health Inequities Grp Minutes_5.13.15</p> <p>HPSM_CAP_4.2.4_Health Inequities Grp Minutes_6.12.15</p> <p>2. HPSM_CAP_4.2.4_Cervical Cancer Screening Analysis PhaseIII</p> <p>HPSM_CAP_4.2.4_HI Mtg Sign In Sheet_7.10.15</p>	<p>1. 03/06/15 and ongoing</p> <p>2. 7/10/15</p>	<p>The Plan did not propose any initiatives in the 2014 QI Work Plan. The Plan had proposed initiatives in the 2013 QI Work Plan but did not demonstrate any progress or tracking of the initiatives listed.</p> <p><u>Recommendation</u></p> <p>Take effective action to address any needed improvement in C&L services.</p> <p>The Plan provided minutes from multiple Health Inequities Group meetings showing that initiatives based on the QI work plan is being discussed. The Plan also submitted a presentation on demographic data on Cervical Cancer Screening which was presented at the Quality Staff meeting and will be presented at the next Health Inequities Workgroup. This item is closed.</p>

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	presented at the Quality Staff meeting and will be presented at next Health Inequities Workgroup meeting scheduled for 2015.			
4.2.5 The Plan did not have a consistent system to assess bilingual employees.	<p>1. The MMCD Policy Letter 99-03 provides "Guidelines for Determining Bilingual Proficiency" on Page 5. The section quoted above in the Findings referred to what the Policy Letters defines as Medical Key Points of Contact.</p> <p>However, the Plan employees that are included in the bilingual proficiency testing are those who are considered to be Non-Medical Key Points of Contact. Hence, bilingual testing materials did not contain medical terms or dialogue for bilingual employee assessment, nor were the materials required to do so based on MMCD Policy Letter 99-03 Guidelines.</p> <p>2. The Plan provides a consistent system for evaluating for assessing</p>	<p>1. HPSM_CAP_4.2.5_MMCDPL9903</p> <p>2. HPSM_CAP_4.2.5_HR.9_Bilingual Pay Policy</p>	<p>1. N/A</p> <p>2. 5/1/15</p>	<p>The Plan conducted in-house bilingual assessments of their bilingual employees' linguistic capability. The Plan used material that did not prove comprehension of spoken language related to both health care settings and Plan member services for the bilingual employee assessment. The Plan could not demonstrate a consistent, standardized and effective system for evaluating their bilingual employees.</p> <p><u>Recommendation</u></p> <p>Implement a consistent, standardized and effective system to assess the linguistic capability of bilingual employees.</p> <p>Non-Medical Key Points of Contact are required to be fluent in managed care terminology, be able to precisely explain nonclinical consent forms (transfer of medical records, admission forms, and advance directives). Non-Medical</p>

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	bilingual employees	<p>HPSM_CAP_4.2.5_Bilingual Certification – Evaluation Form</p> <p>HPSM_CAP_4.2.5_Bilingual Salary Differential Allowance Form</p> <p>HPSM_CAP_4.2.5_Bilingual Testing</p>		<p>Points of Contact are not required to be fluent in medical terminology. This item is open. Please modify the linguistic assessment system to ensure that the fluency requirements for Non-Medical Key Points of Contact are met as stated in MMCD Policy Letter 99-03.</p> <p>10-23-15</p> <p>The Plan now uses an unscripted role-playing session is held where the tester takes the role of a member and asks the applicant being tested questions about Medi-Cal (as if they were a member on a call). This item is closed.</p>
4.3.1 The Plan's breach and security incident reporting process allowed certain unauthorized PHI disclosures to circumvent DHCS reporting	1. Update Breach Notification Decision Tree to clarify the reporting process for all unauthorized PHI disclosures.	1. HPSM_CAP_4.3.1_Breach Notification Decision Tree_revised	1. 7/1/15	<p>Prior to any notification, the Plan utilized a decision tree to determine if a breach or a security incident is reportable to DHCS. The decision tree process allowed incidents or breaches with unauthorized PHI disclosures to bypass DHCS notification if certain conditions were met.</p> <p><u>Recommendation</u></p> <p>Report all breaches and security incidents to DHCS within the required time frames.</p> <p>The Plan modified its Breach notification decision tree clarifying the reporting process for all unauthorized breaches. This item is closed.</p>

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5. Quality Management				
5.1.1 No mechanism to detect and correct under-service by at-risk Providers	<ol style="list-style-type: none"> Develop and complete over and underutilization policy Review service measures with Utilization Management Committee 	<ol style="list-style-type: none"> HPSM_CAP_5.1.1_U M-31 Over and Under Utilization N/A To be Completed HPSM_CAP_5.1.1_U M Committee_08-06-2015 HPSM_CAP_5.1.1_U M Committee_09-22-2015 	<ol style="list-style-type: none"> June 2015 August 2015 	<p>The Plan capitated its primary care Providers and did not have a mechanism to detect and correct under-service by at-risk Providers. The Plan did not require prior authorization for in-network specialty services. This compensation mechanism represented a significant risk in which PCPs would rather refer than provide services in their scope of practice.</p> <p><u>Recommendation</u></p> <p>Develop internal controls and a mechanism to detect and correct under-service by at-risk Providers.</p> <p>The MCP submitted P&P UM-31 that describes how to monitor organization performance as a whole, as well as individual performance of providers and practitioners, when indicated, to ensure appropriate service, coverage and decision-making and to identify, direct and correct any potential patterns of over-utilization or under-utilization of medical services.</p> <p>10/16 - This item will be closed when we receive UM Committee minutes that Service Measures are reviewed</p> <p>10-23-15</p> <p>The Plan submitted the agenda for 8-6-15 UM Committee Meeting and the minutes for the 9-22-15 UM Committee Meeting. This item is closed.</p>

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5.1.2 Governing Body not directing operational QIS	<ol style="list-style-type: none"> 1. The San Mateo Health Commission (governing body) will be briefed on quality activities at biannually with time for discussion and request for direction 2. During the updates, pertinent data gathered from various quality activities will be shared with the San Mateo Health Commission 3. The San Mateo Health Commission will be presented the Annual Quality Evaluation and Annual Work Plan on an annual basis with time for discussion and request for direction 	<ol style="list-style-type: none"> 1. HPSM_CAP_5.1.2_San Mateo Health Commission Agenda _07-08-15 2. HPSM_CAP_5.1.2_San Mateo Health Commission Agenda _07-08-15 3. HPSM_CAP_5.1.2_San Mateo Health Commission Agenda _07-08-15 <p>HPSM_CAP_5.1.2_S MHC Minutes_7-8-15</p>	<ol style="list-style-type: none"> 1. 7/8/2015 2. 7/8/2015 3. 7/8/2015 	<p>The annual review and approval of the QIS, QIS Work Plan and program evaluation were contained in the Governing Body's consent agenda and passed without discussion. Although there were two presentations to the Governing Board regarding HEDIS results and Quality Program issues in February 2014 and August 2013 respectively, there was minimal discussion after these presentations, which cannot be considered active ongoing direction and modification of the QIS.</p> <p><u>Recommendation</u></p> <p>Remove the approval of the QI Work Plan, QIS and annual evaluation from the Governing Body's consent agenda. Ensure active participation by the Governing Body in directing the operational QIS.</p> <p>The MCP submitted an agenda to the San Mateo Health Commission and The San Mateo Community Health Authority Regular Meeting. Specific discussion/Action items were Approval of Quality Improvement Documents; 2014 Q1 Program Evaluation; 2015 Q1 Program Description; and 2015 Q1 Work Plan.</p> <p>10/16 - This item will be closed when we receive Minutes from Meeting on 7/8/2015.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				<p>10-23-15</p> <p>The Plan submitted the meeting minutes to the 7-8-15 San Mateo Health Commission meeting. This item is closed.</p>
<p>5.1.3 QI Committee fails to meet at least quarterly to follow-up on findings and required actions; members fail to attend</p>	<ol style="list-style-type: none"> 1. QI committee to maintain quarterly meetings 2. If the QI committee fails to meet quorum for a scheduled face to face meeting, a conference call will be scheduled. 3. If the scheduled conference call does not meet quorum, the discussion with proceed and email will be used to facilitate committee decisions 	<ol style="list-style-type: none"> 1. N/A 2. HPSM_CAP_5.1.3_QAIC Agenda_2-18-15_Cancelled HPSM_CAP_5.1.3_QAIC Minutes_3-26-15_make up from 2-18-15 3. N/A HPSM_CAP_5.1.3_2015_HPSM Quality Program Description – see page 9 	<ol style="list-style-type: none"> 1. N/A 2. Q1 2015 Meeting cancellation due to lack of quorum Q1 2015 Meeting via conference call that met quorum (March 2015) and ongoing 3. N/A 	<p>The Plan only held three meetings. Minutes were not organized to show follow-up and actions taken. The Medical Director did not attend 2 of 3 meetings, and two Provider representatives did not attend any of the meetings.</p> <p><u>Recommendation</u></p> <p>Encourage participation and attendance of required parties at QAIC meetings. Record minutes from QAIC meetings in a fashion that allows demonstration of follow-up and action items. Meet the contractual requirement of four quarterly meetings.</p> <p>The MCP submitted the Quality Assessment and Improvement Committee meeting notice dated February 18, 2015. This meeting was cancelled. Another Quality Assessment and Improvement Committee meeting noticed was submitted, dated March 26, 2015. This meeting was a make-up meeting from February 18, 2015. Meeting minutes demonstrated participation, attendance of required individuals and also demonstrated follow-up and action of items. 10/16 – This item will be closed when we receive Evidence of quarterly meetings and P&P which indicates Plan’s protocol when</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				<p>quarterly meetings are canceled. 10-23-15</p> <p>The Plan submitted its Quality Program description which contains protocol when a quorum cannot be assembled for a quarterly meeting. This item is closed.</p>
<p>5.1.4 No QI mechanism to evaluate and improve access</p>	<ol style="list-style-type: none"> 1. Grievance and Appeals will generate quarterly reports for the Quality Improvement department to review & evaluate to improve access. Reports will include Grievances by Provider & Member. Medical Director's Designee will validate findings. 2. All substantiated Grievances and Appeals will be referred to Physician Review Committee for further evaluation and action to improve access and/or a CAP will be instituted. 3. Provider Services will develop a Provider survey to improve process to review, evaluate, or improve access service issues. 	<p>1. HPSM_CAP_5.1.4_Q3 2014 CAC Report</p> <p>HPSM_CAP_5.1.4_Q4 2014 CAC Report</p> <p>HPSM_CAP_5.1.4_Q1 2015 CAC G&A Report</p> <p>HPSM_CAP_5.1.4_P RC Minutes_2-4-2015</p> <p>HPSM_CAP_5.1.4_Kannan Recredentialing Profile</p> <p>HPSM_CAP_5.1.4_Tsang Recredentialing Profile</p> <p>HPSM_CAP_5.1.4_P RC Minutes_6-3-2015</p> <p>HPSM_CAP_5.1.4_P RC Minutes_8-5-2015 (No GA Issues)</p>	<ol style="list-style-type: none"> 1. Start Q2 2015 and ongoing 2. Q3 2015 3. Q3 2015 	<p>The 2013-2014 QIS included no description of the process to review, evaluate or improve access; this process was handled by Provider Services. The Plan used a self-reported survey that had never been validated to report access needs.</p> <p><u>Recommendation</u></p> <p>Include the continuous review, evaluation, and improvement of access to and availability of services in the QIS. Employ valid measures of access to guide this process.</p> <p>The MCP submitted three Consumer Advisory Committee Grievance & Appeals Reports for Q3 2014, Q4 2014 and Q1 2015. Reports demonstrated the MCP is reviewing, evaluating and identifying trends to improve access. 10/16 – This item will be closed when we receive the Q3 minutes.</p> <p>10-23-15</p> <p>The Plan minutes from three Peer Review Committee meetings showing that substantiated</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				grievances are being discussed. This item is closed.
5.1.5 No QI Involvement in service issues	<ol style="list-style-type: none"> 1. When service issues are identified and substantiated, through G&A grievance reports analysis & processes, QI will create a Corrective Action Plan appropriate to address the service issue and/or refer offending provider(s) to PRG. 2. QI department will provide Health Education to members when applicable to supplement Providers' efforts for Corrective Action Plan implementation. 3. Provider Services will perform Provider Education to supplement the implementation of the CAP. 4. QI FSR nurses will monitor CAP closure status during mid-cycle credentialing focused site reviews and medical record reviews to validate the closure status of service issues CAPs. 	<ol style="list-style-type: none"> 1. HPSM_CAP_5.1.5_Q1 2015 CAC_G&A Report HPSM_CAP_5.1.5_Q3 2014 CAC Report HPSM_CAP_5.1.5_Q4 2014 CAC Report 	<ol style="list-style-type: none"> 1. Q3 2015 On-going 2. Q3 2015 On-going 3. Q3 2015 On-going 4. Q3 2015 On-going 	<p>The Plan's QIS was primarily directed at clinical measures. Service issues were addressed by individual Departments within the Plan without involvement of QI.</p> <p><u>Recommendation</u></p> <p>Expand the current QIS to include elements of service as well as clinical efforts.</p> <p>The MCP submitted three Consumer Advisory Committee Grievance & Appeals Reports for Q3 2014, Q4 2014 and Q1 2015 which demonstrated service issues that are being identified and substantiated. This item provisionally closed. Please submit:</p> <ol style="list-style-type: none"> 1. Corrective Action Plan that will be created and that will address the service issue and/or refer offending provider(s) to PRG. 2. Provider Education tool that will be used by Provider Services to supplement the implementation of the CAP. 3. A procedure on monitoring to be completed by QI FSR nurses regarding closure status during mid cycle credentialing focused site reviews and medical reviews to validate the closure

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				status of service issues CAP's.
5.2.1 No credentialing and re-credentialing delegation agreements with two subcontractors	<p>1. Include credentialing delegation in overall delegation agreement with San Mateo Behavioral Health & Recovery Services for Medi-Cal benefits</p> <p>2. Execute credentialing agreement with PAMF</p>	<p>1. HPSM_CAP_5.2.1_Service Agreement with BHRS</p> <p>2. HPSM_CAP_5.2.1_HPSM_PAMF Delegation Agreement Credentialing Activities</p> <p>HPSM_CAP_5.2.1_P AMF delegation agreement</p>	<p>1. October 21, 2014</p> <p>2. August 31, 2015</p>	<p>The Plan delegated credentialing and re-credentialing to five entities during the audit period. The Plan did not have formal executed delegation agreements with two of the five entities.</p> <p><u>Recommendation</u></p> <p>Execute delegation agreements for all entities with delegated credentialing and re-credentialing activities.</p> <p>The MCP submitted two non-executed delegation agreements for Palo Alto Medical Foundation and Health Plan of San Mateo/Health Plan of San Mateo and County of San Mateo Health System, Behavioral Health and Recovery Services. This item remains open. Please submit formal executed delegation agreements with Palo Alto Medical Foundation.</p> <p>10/16 – This item will be provisionally closed when we receive Copy of delegation agreement.</p> <p>10-23-15</p> <p>The Plan submitted the Delegation Agreement with the Palo Alto Medical Foundation. This item is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
5.2.2 Delegation agreements for credentialing and re-credentialing did not include clauses regarding termination of agreements and remedies for not fulfilling agreement terms	1. Amend Letters of Agreement with Stanford and Lucile Packard to include termination clause	<p>1. Proposed amendments – currently in route for execution:</p> <p>HPSM_CAP_5.2.2_ Amendment to HPSM-SHC Credentialing Agreement</p> <p>HPSM_CAP_5.2.2_ Amendment to HPSM-LPCH Credentialing Agreement</p>	1. August 31, 2015	<p>Two delegation agreements did not include clauses for actions and remedies for subcontract termination or breach of subcontract agreements and terms.</p> <p><u>Recommendation</u></p> <p>Include clauses for agreement termination and remedies for non-fulfillment of the agreement terms in delegation subcontracts.</p> <p>The MCP submitted two Amendments to Letter of Agreement Between Health Plan of San Mateo and Lucille Packard Children’s Hospital Medical Group/Health Plan of San Mateo and Stanford Hospital and Clinics which included a termination clause.</p> <p>This item is provisionally closed when we receive Copy of HPSM-SHC Credentialing Agreement</p> <p>10-23-15</p> <p>The Plan submitted the amended SHC delegation agreement that contains a termination clause. This item is closed.</p>
5.2.3 No annual oversight, monitoring and evaluation of three subcontractors	<p>1. Perform Credentialing Delegation Audit of Palo Alto Medical Foundation</p> <p>2. Perform Credentialing Delegation Audit of Stanford</p>	<p>1. HPSM_CAP_5.2.3_ PAMF Cred Audit Results Letter for 2014</p> <p>2. HPSM_CAP_5.2.3_ Stanford Cred Audit Results Letter for 2014</p>	<p>1. Completed December 16, 2014</p> <p>2. Completed December 5, 2014</p>	<p>The Plan could not provide annual oversight, monitoring and evaluation documentation for three of the entities to whom there was delegation of credentialing and re-credentialing. This was confirmed during interviews of Plan staff.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	3. Perform Credentialing Delegation Audit of San Mateo Medical Center	3. HPSM_CAP_5.2.3_SMMC Cred Audit Results Letter for 2014	3. Completed December 17, 2014	<u>Recommendation</u> Perform annual oversight, monitoring and evaluation of credentialing and re-credentialing activities on all delegated entities. The MCP submitted three delegated credentialing audits for Stanford's provider network, Palo Alto Medical Foundation and San Mateo Medical Center provider network demonstrating oversight and evaluation of credentialing and re-credentialing. This item is closed.
6. Administrative and Organizational Capacity				

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
6.1.1 Medical Director did not ensure standards for acceptable medical care were met	<ol style="list-style-type: none"> 1. Upon receipt of member's clinical complaint grievance, Medical Director will communicate to the provider the nature of the complaint and inform the provider that the plan's Medical Director's physician designee' will perform a quality facility site & medical record review to fully investigate the clinical complaint, to ensure standards for acceptable medical care were met. 2. Designee will fully evaluate all facts pertaining to the medical QoC grievance. Provider's facility will be reviewed and member's medical record will be abstracted to ensure standards for acceptable medical care were met. 3. After full investigation, should standards for acceptable medical care be determined not to have been met, then a CAP will be instituted. 	<ol style="list-style-type: none"> 1. HPSM_CAP_6.1.1_QI-03_Review and handling of QOC complaints and concerns HPSM_CAP_6.1.1_Facility Site Review DHCS MMCD Attachment A HPSM_CAP_6.1.1_Medical Record Review DHCS MMCD Attachment B 2. N/A: To be completed 3. N/A: To be completed 	<ol style="list-style-type: none"> 1. Policy completed July 2015 2. 2 and 3. Start July 2015 and ongoing 3. Start July 2015 and ongoing 	<p>A review of a child Member's grievance, filed by the parent, showed that numerous Member clinical complaints were not reflected in the medical record.</p> <p><u>Recommendation</u></p> <p>Enforce standards of acceptable medical care throughout the Plan.</p> <p>The Plan has submitted documents: Q1-03 Review and handling of QOC complaints and concerns, Facility site Review DHCS MMCD Attachment A, and Medical Record Review DHCS MMCD Attachment B.</p> <p>As of July 2015, Plan has started a system to fully evaluate and investigate all facts pertaining to the medical QoC grievances to ensure the standards for acceptable medical care are met according to the requirements.</p> <p>This item is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
6.1.2 Medical Director did not fully investigate or resolve quality of care grievances	<ol style="list-style-type: none"> 1. Quality of Care policy revised 2. Medical Director & Medical Director physician designee' will fully investigation QoC grievance via a Facility Site & Medical Record Review, to resolve QoC grievance & ensure standards for acceptable medical care are met. 3. Plan's Medical Director will contact Provider to discuss substantiated or unsubstantiated complaint(s) and/or discrepancies in medical record documentation or condition of facility. 4. After full investigation and determination that grievance was substantiated; a Corrective Action plan will be instituted. 	<ol style="list-style-type: none"> 1. HPSM_CAP_6.1.2_QI-03_Review and handling of QOC complaints and concerns 2. HPSM_CAP_6.1.2_Facility Site Review DHCS MMCD Attachment A HPSM_CAP_6.1.2_Medical Record Review DHCS MMCD Attachment B 3. N/A: To be completed 4. N/A: To be completed 	<ol style="list-style-type: none"> 1. Revised policy July 2015 2. July 2015 and ongoing 3. July 2015 and ongoing 4. July 2015 and ongoing 	<p>The Plan's Medical Director designee did not completely evaluate all facts pertaining to the resolution of a medical quality of care grievance.</p> <p><u>Recommendation</u></p> <p>Resolve medical quality of care grievances only after complete investigation by the Medical Director.</p> <p>The Plan has submitted documents: Q1-03 Review and handling of QOC complaints and concerns, Facility site Review DHCS MMCD Attachment A, and Medical Record Review DHCs MMCD Attachment B.</p> <p>As of July 2015, Plan's Medical Director and Medical Director Physician designee have started a system to fully investigate QoC grievance to endure standards for acceptable medical care are met.</p> <p>This item is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
<p>6.1.3 Medical Director did not actively participate in the Plan grievance system or in the integration of grievance information into quality improvement activities</p>	<ol style="list-style-type: none"> 1. Revised the Policy & Procedure Manual, Procedure: QI-03, Title: Review and Handling of Quality of Care Complaints and Concerns. Reflects the designation of the duties to the associate medical director. 2. Plan has revised the Policy & Procedure Manual, Procedure: GA-07 to state that the chief medical officer can designate an associate medical director to participate in and manage grievances. 3. Plan follows SGAC Committee Charter for membership 4. Quality Program updated to note that Chief Medical Officer, Deputy Chief Medical Officer, and Associate Medical Directors are involved in grievances and incorporate them into quality improvement activities. 5. The Grievance and Appeals Manager presents a quarterly report to the Quality Assessment 	<ol style="list-style-type: none"> 1. HPSM_CAP_6.1.3_QI-03 Review-Handling of Quality of Care Complaints - Concerns 2. HPSM_CAP_6.1.3_GA-07 Member Grievance Procedure for Non-Medicare LOB 3. HPSM_CAP_6.1.3_SGAC Committee Charter 4. HPSM_CAP_6.1.3_2015 HPSM Quality Program Plan 5. HPSM_CAP_6.1.3_QIC Agenda 06-24-2015 	<ol style="list-style-type: none"> 1. QI-03 revised 06/20/2015 2. GA-07 revised 09/09/2014 3. Completed – Policy in place throughout the audit period. 4. Quality Improvement Program Description June 2015 5. G&A 	<p>The Medical Director failed to perform clinical oversight to ensure proper identification of clinical/quality of care grievances. There was no communication of grievance data to the Plan departments for analysis. There was no formal plan for systematic aggregation, analysis, tracking and trending of Plan grievance data and use in Plan quality improvement activities. Clear and concise explanations of appeal decisions were not always provided. A description of criteria and guidelines used, consistent application of those guidelines, and clinical reasons for medical necessity decisions were not always provided. The Medical Director did not ensure that standards for acceptable medical care were always followed. Quality of care grievances were not completely investigated or resolved.</p> <p><u>Recommendation</u></p> <p>Actively participate and be involved in all aspects of the Plan grievance and appeals process. Integrate grievance data into the Plan's quality improvement activities.</p> <p>The Plan submitted documents: revised Q1-03 Review and handling of QOC complaints and concerns, revised GA-07 member grievance procedure for Non-Medicare LOB, SGAC Committee Charter, 2015 HPSM Quality Program Plan, and QIC Agenda for meeting on 6/24/2015. This item is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	& Improvement Committee.		presentation to QIC on 6/24/2015	
6.2.1 The Plan did not have internal controls to ensure that medical decisions were not influenced by fiscal or administrative management considerations	<ol style="list-style-type: none"> 1. Review primary care provider scope of practice in primary care provider contract 2. Update Utilization Management policy on over and under utilization 3. Review primary care provider and specialist utilization trends during Utilization Management Committee meetings 	<ol style="list-style-type: none"> 1. HPSM_CAP_6.2.1_ Attachment C Scope of Capitated Services HPSM_CAP_6.2.1_ HPSM Medi-Cal PCP Provider Agreement 2. HPSM_CAP_6.2.1_ UM-31 Over and Under Utilization 3. N/A: To be completed 	<ol style="list-style-type: none"> 1. June 2015 2. June 2015 3. Q3 2015 	<p>The combination of capitated PCPs and the lack of either an authorization requirement or tracking systems for in-network Specialty Providers presented a considerable risk for unnecessary specialty referrals. Although the Plan specified which services PCPs were expected to perform, (Attachment C of the Primary Care Physician Contract, Scope of Capitated Services), it had no means to ensure that financial considerations were not limiting the provision of these services.</p> <p><u>Recommendation</u></p> <p>Implement internal controls to ensure that medical decisions, including scope of practice, are not influenced by fiscal or administrative concerns.</p> <p>The Plan submitted documents: Attachment C Scope of Capitated services, HPSM Medi-Cal PCP Provider agreement, P&P Um-31 Over and Under Utilization. This item is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
6.2.2 Barriers to annual health assessments and urgent care visits due to fiscal considerations	<ol style="list-style-type: none"> 1. Review and update primary care provider scope of practice in primary care provider contract 2. Update Utilization Management policy on over and under utilization 3. Monitor access related grievances during QI Committee meetings 	<ol style="list-style-type: none"> 1. HPSM_CAP_6.2.2_ Attachment C Scope of Capitated Services HPSM_CAP_6.2.2_ HPSM Medi-Cal PCP Provider Agreement 2. HPSM_CAP_6.2.2_ UM-31 Over and Under Utilization 3. N/A: to be completed 	<ol style="list-style-type: none"> 1. June 2015 2. June 2015 3. Q3 2015 	<p>The Plan's designation of Special Member status for Members not yet paneled to a PCP Provider, together with its pay for performance program, created barriers for routine care.</p> <p><u>Recommendation</u></p> <p>Ensure that fiscal or administrative management considerations do not result in barriers to medical care.</p> <p>The Plan submitted documents: Attachment C Scope of Capitated services, HPSM Medi-Cal PCP Provider agreement, P&P Um-31 Over and Under Utilization. This item is closed.</p>
6.4.1 The Plan did not ensure completion of Provider Training	<ol style="list-style-type: none"> 1. Implement provider attestation to training 	<ol style="list-style-type: none"> 1. HPSM_CAP_6.4.1_ Acknowledgement of Receipt of Prov Training HPSM_CAP_6.4.1_ Completed Acknowledgement of Prov Training - Sample 	<ol style="list-style-type: none"> 1. Completed April 14, 2015 	<p>The Plan emailed or mailed training materials if the Plan's representatives could not schedule a training appointment. Receipt of Provider Training Materials through e-mail or mail did not ensure completion of the Plan's Provider Training. The Plan updated their system to show that the materials were sent. However, the Plan did not conduct any follow-up review to ensure completion or competency of the material.</p> <p>The Plan interpreted the Contract requirements for Provider Training as applicable to Primary Care Providers only. While the Contract cites PCP training requirements, the contract language is specific in stating that the Plan must conduct training for all newly contracted providers.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				<p>The Plan did not conduct Provider Training for providers who joined medical groups with a prior relationship with the Plan. It was the Plan's expectation that medical groups would share relevant aspects of the Plan's training with new providers upon activation with the Plan.</p> <p><u>Recommendation</u></p> <p>Ensure the completion of new Provider Training.</p> <p>The Plan submitted documents: Acknowledgement of receipt of provider training, and completed acknowledgment of provider training sample.</p> <p>This item is closed.</p>
6.4.2 The Plan did not train new Providers within the time requirements	<p>1. Update provider application / credentialing policy to require provider acknowledge receipt of training before presentation to credentialing committee</p> <p>2. Implement required attestation to acknowledge completion of training as part of provider application / credentialing process</p>	<p>1. HPSM_CAP_6.4.2_PS 01-03 Provider Training Procedure</p> <p>2. HPSM_CAP_6.4.2_Acknowledgement of Receipt of Prov Training</p>	<p>1. Completed April 14, 2015</p> <p>2. Completed April 14, 2015</p>	<p>The Plan did not complete new Provider Training timely. Our review showed that 17 of 20 providers did not complete the Provider Training within the time frame required. Provider Services' representatives did not have documentation to validate completed Provider Training. The only evidence of completion was the Plan's Provider Services representative's note in the Plan's provider database.</p> <p><u>Recommendation</u></p> <p>Conduct training for all newly active Providers within 10 working days and complete the training within 30 calendar days.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				The Plan submitted documents: PS 01-03 Provider Training Procedure and Acknowledgement of receipt of provider training. This item is closed.
6.5.1 The Plan did not report all cases of suspected Fraud and Abuse	<p>HPSM believes it is following the contract statement of reporting “to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred.” The situations referenced in this item as “incidents” are those where, after an internal review, there was no reason to believe fraud and/or abuse had occurred. Therefore, per contract, these situations were not reported.</p> <p>HPSM will continue to report to DHCS all cases where there is reason to believe fraud and/or abuse has occurred.</p>	N/A	Completed prior to audit period – No new action required	<p>The Plan defined whether the occurrence was an incident or intentional Fraud and Abuse. An incident was defined as “logically explainable”. The Plan only reported verified cases of fraud and abuse to DHCS. There were four cases in the Plan’s Fraud and Abuse log that were classified as incidents.</p> <p><u>Recommendation</u></p> <p>Report all suspected and actual cases of fraud and abuse.</p> <p>This item is closed. Please continue to submit fraud cases that meet the threshold of suspected fraud, waste or abuse.</p>
6.5.2 The Plan did not implement its Anti-Fraud and Abuse program as described in its Compliance Plan	<ol style="list-style-type: none"> FWA is a standing agenda item for the Compliance Committee. HPSM will be implementing 	<ol style="list-style-type: none"> Example of most recent Compliance Committee Agenda – 5/1/2015: HPSM_CAP_6.5.2_Compliance Committee Agenda_050115 	<ol style="list-style-type: none"> Completed - In place prior to and through the entire audit review period. Software 	<p>The Compliance Committee did not develop and implement procedures that identified, investigated or provided a prompt response against Fraud and Abuse on an ongoing basis as required by the Contract. In addition, the Plan did not engage in proactive activities to prevent Fraud and Abuse.</p> <p>The Compliance Committee meetings served</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>software to identify trends that may indicate potential FWA cases. These will be brought to the Compliance Committee for review. Trends from these reports will form the basis for the proactive identification for additional processes and procedures.</p>	<p>2. N/A: To be completed</p>	<p>implementation – 12/31/2015</p>	<p>only to discuss Fraud and Abuse cases as issues arose. Committee meeting discussions did not pursue the development of proactive activities to detect Fraud and Abuse. The Compliance Committee only examined each Fraud and Abuse case as isolated incidents instead of as potential failures in the Plan's organization, structure, or systems.</p> <p><u>Recommendation</u></p> <p>Fulfill Compliance Committee responsibilities to develop and implement proactive procedures to detect fraud and abuse.</p> <p>The Plan has submitted documents: Example of most recent Compliance Committee Agenda 5/1/2015. Per Plan, it will be implementing software to identify trends that may indicate potential FWA cases.</p> <p>This item is closed.</p>

Submitted by:
Title:

Date:

**ATTACHMENT A
Corrective Action Plan Response Form**



Health Plan of San Mateo:

Review/Audit Type: DHCS A&I Medical Review Audit

Review Period: August 1, 2013 – 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 Documentation	Completion/ Expected Completion Date	DHCS Comments
State Supported Services				
SSS.1 The Plan did not ensure inclusion of all Contract required State Supported Services codes for claims payment	1. A4649 (surgical supply, miscellaneous) has been payable by HPSM since 8/1/2009.	1. HPSM_CAP_SSS.1_Explanation of configuration HPSM_CAP_SSS.1_CO-02-10_Processing of	1. July 2015	The Plan provided a list of all state supported service procedure codes which it pays for. The Plan provided screenshots from their claims program, but the codes X1516 and X1518 or their HCPCS equivalent A4649 were not listed. <u>Recommendation</u>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>2. Develop Desk Procedure to be used by Claims staff to provide instructions for prompt and accurate payment</p> <p>3. Pay services that were previously payable with the billing of HCPCS code X1516 and X1518 using A4649 as required by Medi-Cal Bulletin dated 7/27/2009.</p>	<p>Claims for Abortion Services.</p> <p>2. HPSM_CAP_SSS.1 _ Abortion Services Desk Procedure- Code A4649</p> <p>3. HPSM_CAP_SSS.1 _ Medi-Cal Bulletin X1516 and X1518.</p>	<p>2. July 2015</p> <p>3. August 2009</p>	<p>Include all the required state-supported services procedure codes in payment database.</p> <p>The Plan developed a desktop procedure for the manual processing of claims with the code A4649. This item is closed.</p>

Submitted by:
Title:

Date: