

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

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

Contract Number: 08-85213

Audit Period: August 1, 2013  
Through  
July 31, 2014

Report Issued: April 28, 2015

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## I. INTRODUCTION

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

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

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

HPSM’s Provider network includes independent Providers practicing as individuals, small and large group practices, an independent community clinic with two sites, and San Mateo Medical Center (SMMC), which operates multiple clinic sites.

As of July 2014, the Plan served approximately 118,956 Members through the following programs: Medi-Cal (102,748), Medicare (11,464), Healthy Kids (3,679), HealthWorx (1,065).

## II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of August 1, 2013 through July 31, 2014. The on-site review was conducted from November 3, 2014 through November 14, 2014. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An exit conference was held on March 4, 2015 with the Plan. The Plan was allowed 15 calendar days from the date of the exit conference to provide supplemental information addressing the draft audit report finding. After the exit conference, the Plan submitted supplemental information for consideration. The auditors evaluated the information and incorporated applicable changes to this report.

The audit evaluated six categories of performance: Utilization Management (UM), Continuity of Care, Access and Availability to Care, Members' Rights, Quality Management (QM), and Administrative and Organizational Capacity.

The summary of the findings by category follows:

### **Category 1 – Utilization Management**

The Plan did not have a process to ensure consistent application of Utilization guidelines and had no mechanism to detect under and over-utilization of health care services. The Utilization Management Program was not continuously updated and improved. Delegated utilization management activities were not monitored.

Medical necessity denials were not consistently reviewed and decided by a licensed physician. The Plan did not coordinate medically necessary care as identified by its prior authorization system. Medical and Pharmacy prior authorizations were not consistently processed within the required time frame.

The Plan had no referral tracking process to examine open authorizations, unused authorizations or the outcome of denials, deferrals or modifications. It did not integrate reports on referrals with the Quality Improvement System (QIS).

Communication to Members and Providers during appeals was not consistent, clear or concise.

### **Category 2 – Case Management and Coordination of Care**

The Plan did not comply with the requirements for Basic Case Management, which included Initial Health Assessments and coordination of linked services. The Plan did not ensure timely completion of Members' Initial Health Assessments.

The Plan did not have a complex case management program and did not provide any complex case management to eligible Members.

### **Category 3 – Access and Availability of Care**

The Plan's Annual Provider Survey did not measure the length of time to obtain various appointments and did not reflect compliance with access requirements. The Plan did not monitor wait times at Providers' offices, for Providers to answer and return calls, or for first prenatal care visit. When the Plan identified deficiencies, it did not take appropriate corrective action.

The Member Services Call Center did not maintain sufficient knowledgeable staff to provide covered services to Members and took no corrective action when call monitoring deficiencies were identified.

The Plan did not pay all Emergency Services claims, and reduced payments for others based on diagnosis without obtaining medical documentation. The claim remittance advices did not contain the specific rationale used to determine why the claim was rejected or identify additional information needed for payment or appeal. The Plan did not process complete claims within the required time frame and failed to forward misdirected claims to the appropriate Providers.

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

### **Category 4 – Member's Rights**

The Plan's grievance system had significant systemic deficiencies in capturing and identifying grievances, processing grievances, and addressing problems identified. The number of grievances identified was understated due to the systems' failure to capture all complaints and expressions of dissatisfaction, and lack of clinical oversight in the identification of quality of care grievances. Those that were captured were not processed adequately as they were not fully resolved, had required correspondence that was late, not sent, or not translated. Grievance information was not used to review the operation of the grievance system, or to identify emergent patterns of grievances, or communicated to the appropriate Plan departments, or used for quality improvement.

The Plan's website did not have navigation options for any language other than English. 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 to access of health care services and health education.

The Plan's assessments of bilingual employees' linguistic capability were inconsistent and did not contain medical terminology.

The Plan did not propose any Cultural and Linguistic initiatives to include in the 2014 Quality Improvement Work Plan and did not implement initiatives from the 2013 Quality Improvement Work Plan.

The Plan did not report suspected security incidents to the Department.

### **Category 5 – Quality Management**

The Plan had no Quality Improvement mechanism to evaluate and improve access or a mechanism to detect and correct under-service by at-risk Providers. The Plan's Quality Improvement System was primarily directed at clinical measures. Service issues were addressed by individual Departments within the Plan without involvement of Quality Improvement.

The Plan had no credentialing delegation agreements with two delegated entities and conducted no annual oversight, monitoring and evaluation of three delegated entities.

### **Category 6 – Administrative and Organizational Capacity**

The Plan's Medical Director did not fully investigate medical quality of care grievances, did not actively participate in the grievance system, and did not integrate grievance information into quality improvement activities.

The Plan did not have internal controls to ensure that medical decisions were not influenced by fiscal or administrative management considerations. The Plan specified which services PCPs were expected to perform but had no means to ensure that financial considerations were not limiting the provision of those services. Fiscal or administrative management considerations resulted in barriers to annual health assessments and urgent care visits.

The Plan did not train all new Providers within the time frame requirements.

The Plan did not report all cases of suspected Fraud or Abuse, and did not implement its Anti-Fraud and Abuse Program.

### **III. SCOPE/AUDIT PROCEDURES**

#### **SCOPE**

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

#### **PROCEDURE**

The on-site review was conducted from November 3, 2014 through November 14, 2014. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

#### **Category 1 – Utilization Management**

Prior Authorization Requests: 24 medical and 20 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review. A random sample of 75 prior authorization requests was examined to determine the prevalence of medical necessity denials by a non MD.

Notification of Prior Authorization Denial, Deferral, or Modification: 66 denial and modification letters were reviewed for written notification requirements.

Appeal Procedures: 42 prior authorization appeals were reviewed for appropriate and timely adjudication.

#### **Category 2 – Case Management and Coordination of Care**

Coordination of Care: 20 records were included in a review of coordination of care between the Plan, PCP, Member and other services.

California Children's Services (CCS): 6 medical records were reviewed for evidence of coordination of care between the Plan and CCS Providers.

Individual Health Assessment: 20 medical records were reviewed for completeness and timely completion.

### **Category 3 – Access and Availability of Care**

Emergency Service Claims: 25 emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: 25 family planning claims were reviewed for appropriate and timely adjudication.

### **Category 4 – Member’s Rights**

Grievance Procedures: 80 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

### **Category 5 – Quality Management**

Medical Records: 20 medical records were reviewed for completeness.

Informed Consent: 10 informed consent records were reviewed.

### **Category 6 – Administrative and Organizational Capacity**

New Provider Training: 20 new Provider training records were reviewed for timely Medical Managed Care program training.

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

**❖ COMPLIANCE AUDIT FINDINGS ❖**

**PLAN:** Health Plan of San Mateo

AUDIT PERIOD: August 1, 2013 through July 31, 2014

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**CATEGORY 1 - UTILIZATION MANAGEMENT**

**1.1**

**UTILIZATION MANAGEMENT PROGRAM**

**Utilization Management (UM) Program Requirements:**

Contractor shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services.... (as required by Contract)  
COHS Contract A.5.1

There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.  
COHS Contract A.5.2.B

**Under- and Over-Utilization:**

Contractor shall include within the UM Program mechanisms to detect both under- and over-utilization of health care services.  
COHS Contract A.5.4

**SUMMARY OF FINDINGS:**

**1.1.1 No process to ensure consistent application of Utilization Guidelines**

The Plan must consistently apply Utilization Review guidelines (*Contract, Exhibit A, Attachment 5(2) (B)*).

The Plan did not have a mechanism in place to ensure the consistent application of guidelines. No inter-rater reliability studies were conducted of nursing staff who applied the guidelines. There was no mechanism in place to ensure the consistency or appropriateness of medical necessity denials made by Medical Directors. The Plan was not in compliance with the requirement to ensure the consistent application of guidelines.

**1.1.2 No mechanism to detect under and over-utilization of health care services**

The Plan is required to have mechanisms within the Utilization Management (UM) Program to detect both under- and over-utilization of health care services (*Contract, Exhibit A, Attachment 5(4)*).

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. The Plan was not in compliance with the requirement to have UM mechanisms to detect both over-and under-utilization.

**1.1.3 UM Program not continuously updated and improved**

The Plan is required to continuously update and improve its UM program (*Contract, Exhibit A, Attachment 5(1)*).

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.

## ❖ COMPLIANCE AUDIT FINDINGS ❖

**PLAN:** Health Plan of San Mateo

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### **RECOMMENDATIONS:**

- 1.1.1 Establish a method of ensuring the consistency of guideline application; to include a method for ensuring denials made by Medical Directors are appropriate and consistent.
- 1.1.2 Implement a systematic method of detecting over-and under-utilization for services across the population.
- 1.1.3 Continuously update and improve the UM program, using QI methodology and data, including data from denial rates and overturned appeals.

## ❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Health Plan of San Mateo

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1.2

### PRIOR AUTHORIZATION REVIEW REQUIREMENTS

#### **Prior Authorization and Review Procedures:**

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

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

#### **Exceptions to Prior Authorization:**

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

COHS Contract A.5.2.G

#### **Notification of Prior Authorization Denial, Deferral, or Modification:**

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

COHS Contract A.13.8.A

### **SUMMARY OF FINDINGS:**

The Plan required Prior Authorization (PA) for selected services including Durable Medical Equipment and out-of-network services; it did not require PA for routine in-network specialty consultation. The Plan was not compliant in the use of qualified personnel, adherence to time frames, clear communication of decisions, and coordination of care. The Plan improperly requested medical information that was not reasonably necessary for a decision, and reduced the scope of services provided for selected diagnoses.

#### **1.2.1 Medical necessity denials not reviewed and decided by licensed physician**

The Plan must ensure that a Qualified Physician (or Pharmacist, for Pharmacy PAs) reviews all denials that are made, whole or in part, on the basis of medical necessity (*Contract, Exhibit A, Attachment 5 (2) (A)*).

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). The Plan maintained that Medical Directors actually performed the review, even if not documented in the NOA letter. The Plan's internal records failed to document this review; one file contained the name of a consulted Medical Director; one contained a reference to consulting an unnamed Medical Director, and one had no mention of Medical Director involvement.

A 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. In contrast, all Pharmacy denials reviewed in the verification study were signed by a licensed physician. The Plan was not in compliance with requirements for a qualified physician issuing medical necessity denials.

## ❖ COMPLIANCE AUDIT FINDINGS ❖

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### 1.2.2 Time frames exceeded for Prior Authorization

The Plan is required to process routine PAs within five working days from receipt of the information reasonably necessary to render a decision, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member requests an extension, or the need for additional information is in the Member's interest. The decision to defer must be communicated to the physician and Provider. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such (*Contract Exhibit A, Attachment 5, 3(H)*).

The Plan did not consistently meet PA processing time frame. 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. 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.

Pharmacy PAs are to be denied or approved within 24 hours or one business day. The Plan improperly deferred Pharmacy PAs for longer than 24 hours (*CA W&I 14185(a) (1)*). The Plan incorrectly interpreted requirements for Pharmacy PA to allow a deferral period. In a verification study of 20 Pharmacy PA files reviewed, 10 were not denied or approved within 24 hours or one business day. The Plan was not in compliance with time frames for medical or pharmacy PA decision making.

### 1.2.3 NOA Letters' explanation of denial decision incomplete and/or inaccurate

NOA letters are required to contain a clear and concise explanation of the reasons for the Plan's decision, including a description of the criteria used, and the clinical reasons for the decision regarding medical necessity (*APL04-006 and CA H&S §1367.01(h) (4)*).

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.

### 1.2.4 Medical information requested that was not reasonably necessary for a determination

The Plan may request no more medical information than that reasonably necessary to make a determination (*CA H&S §1367.01(g)*).

The Plan routinely denied PA when requests for additional information from Providers were not fulfilled. The Plan improperly requested the "time frame over which weight gain had occurred" as a requirement for approval of an FDA approved drug to treat obesity. The Provider had provided information that the Member was an obese patient with a documented BMI, concomitant sleep apnea, a documented failure eight months earlier on another drug, a nutritionist consult recorded with name and date of the nutritionist nine months earlier, and a subsequent failure to lose weight on diet and exercise. 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.

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### 1.2.5 The Plan did not coordinate medically necessary care as identified by the PA system

The Plan is responsible for the coordination of care provided to Members, including all Medically Necessary services delivered both within and outside the Plan's Provider network (*Contract, Exhibit A, Attachment 11(1)*).

The Plan's PA system denied medically necessary services which were a covered benefit for administrative reasons. The Plan did not subsequently coordinate care for these services. Examples included:

- PAs where no provider was specified. Instead of directing the Member to an in-network provider, the Plan denied the service.
- Requests for multiple services were denied in whole, and not modified to approve those that were a medically necessary covered benefit. Instead, the Member needed to have the PA resubmitted, including only those that the Plan would approve.
- PA requests submitted by a non-contracted Provider were denied, and the Plan did not coordinate the Member's care by redirecting to a contracted Provider.

The Plan denied medically necessary covered benefits for administrative reasons. These denials required resubmission of requests. Care coordination would ensure that needed services were rendered. Despite having direct knowledge that a medically necessary service had been denied, the Plan did not coordinate medically necessary services within and outside the Provider network.

### **RECOMMENDATIONS:**

- 1.2.1 Document Medical Director review of denial by reason of medical necessity. Require Medical Directors sign medical necessity NOA letters.
- 1.2.2 Process PA requests according to required time frames. Implement systems that ensure adequate resources and reporting mechanisms are in place.
- 1.2.3 Clearly and concisely explain the specific reason, including a description of the criteria used, for denial in NOA letters.
- 1.2.4 Request only the medical information reasonably necessary to make a determination of medical necessity when considering a PA request.
- 1.2.5 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.

## ❖ COMPLIANCE AUDIT FINDINGS ❖

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1.3

### REFERRAL TRACKING SYSTEM

#### Referral Tracking System:

Contractor is responsible to ensure that the UM program includes... An established system to track and monitor services requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified prior authorizations, and the timeliness of the determination.  
COHS Contract A.5.1.F

#### SUMMARY OF FINDINGS:

##### 1.3.1 No referral tracking system

The Plan is required to track authorized, denied, deferred, or modified prior authorizations, and the timeliness of the determination (*Contract, Exhibit A, Attachment 5(1) (F)*).

The Plan did not have a referral tracking process. Although Plan *Policy#: HS-03, Utilization Review and Care Coordination/Case Management Program* discussed the generation of reports for UM, the Plan had not implemented any system to track referrals, nor had this been delegated to PCPs. The Plan's boilerplate PCP contract contained no language regarding delegation of referral tracking. The Plan was not compliant with the requirement for referral tracking. It had no process to examine open authorizations, unused authorizations or the outcome of denials, deferrals or modifications.

##### 1.3.2 UM activities not integrated with Quality Improvement System (QIS)

The Plan is required to integrate UM activities into the Quality Improvement System. The Plan must implement a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff (*Contract, Exhibit A, Attachment 5(1) (G)*).

There was no integration of UM activities with QI, or of UM reports to QIS staff. The Plan was not compliant with the requirement to integrate reports on referrals with the QIS.

#### RECOMMENDATIONS:

- 1.3.1 Track all prior authorized referrals, either directly or through appropriate processes of delegation and oversight.
- 1.3.2 Integrate referral tracking information with the Quality Improvement System.

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1.4

### PRIOR AUTHORIZATION APPEAL PROCESS

#### Appeal Procedures:

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

### **SUMMARY OF FINDINGS:**

#### **1.4.1 Time frame was exceeded for resolution and notification**

The Plan must consistently follow timelines for standard appeal resolution, expedited appeal resolution, extension of timelines and sending of acknowledgment and resolution letters (*42 CFR, § 438.410(2) (3) (c)* and *Policy #: GA-08, Member Appeal Procedure for Non-Medicare Lines of Business, paragraphs 5.4, 5.10.1 and 7.4*).

A verification study of 42 PA Appeals was conducted. The resolution letter was late in two instances and one expedited appeal resolution letter was late. Two 14-day appeal extension letters were not sent to the Member. One appeal acknowledgment letter was sent late and another was not sent. The Plan was not in compliance with the requirements for appeals timelines.

#### **1.4.2 Appeal letters were not translated into threshold language**

The Plan must consistently follow guidelines requiring that written informing materials used in the grievance and appeals system are fully translated into the requested language and that the grievance system address the linguistic and cultural needs of its enrollee population (*Contract, Exhibit A, Attachment 9, (13) (2)* and *CCR, Title 28 § 1300.68(b) (3)* and *Policy#: GA-08, Member Appeal Procedure-Non Medicare Lines of Business, paragraphs 3.3, 3.3.1, 3.3.1.1*).

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. The Plan was not in compliance with the language requirements for appeals letters.

#### **1.4.3 Communication to Members and Providers during appeals were not consistent, clear or concise**

The Plan must consistently follow guidelines requiring that data sent to the Member and Provider in communications during the course of the appeals process is clear and concise and that reasons for Plan decisions are concisely explained, including a description of the criteria and guidelines used in decision making and the clinical reasons for decisions regarding medical necessity (*CA H&S § 1367.01(g) (h) (4)*).

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. There was inconsistency in the use of deficiency checklists which were a part of the Member resolution letter. There was no uniform agreement as to whether a checked box next to an item meant that the item had been obtained or was deficient. One letter to a Member only contained the general statement "Provider did not provide enough medical information". The Plan was not in compliance with the guidelines regarding appeals communications with the Members and Providers.

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**RECOMMENDATIONS:**

- 1.4.1 Follow all appeal and letter time frames.
- 1.4.2 Translate all appeal letters to threshold languages.
- 1.4.3 Consistently and clearly communicate all requirements to Providers and Members.

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1.5

### DELEGATION OF UTILIZATION MANAGEMENT

#### **Delegated Utilization Management (UM) Activities:**

Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.

COHS Contract A.5.5

#### **SUMMARY OF FINDINGS:**

##### **1.5.1 No quarterly reporting on delegated activities by UM delegated entity**

The Plan is accountable for delegated activities, including the continuous monitoring, evaluation and approval of the delegated functions (*Contract, Exhibit A, Attachment 4(6) (A) (3)*).

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.

#### **RECOMMENDATIONS:**

- 1.5.1 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.

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**CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE**

**2.1**

**CASE MANAGEMENT AND COORDINATION OF CARE: WITHIN AND OUT-OF-PLAN**

**Case Management and Coordination of Services:**

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

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

COHS Contract A.11.1

**Out-of-Plan Case Management and Coordination of Services:**

Contractor shall implement procedures to identify individuals who may need or who are receiving services from out-of-plan providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for services...

COHS Contract A.11.6

**SUMMARY OF FINDINGS:**

The Plan is required to ensure the provision of Comprehensive Medical Case Management to each Member. The Plan is required to maintain procedures for monitoring the coordination of care provided to Members. These services can be provided through either basic or complex case management based on the medical needs of the Member (*Contract A18, Exhibit A, Attachment 11(2)*).

**2.1.1 Requirements for Basic Case Management were not met**

Basic Case Management services are to be provided by the Primary Care Provider in collaboration with the Plan and shall include Initial Health Assessment (IHA) and coordination of linked services (*Contract A18, Exhibit A, Attachment 11(2)(A)*).

The requirements for Basic Case Management, which include Initial Health Assessment (IHA) and linked services (Early Intervention / Developmental Disabilities [EIDD]) were not met. 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). The Plan was not compliant with the requirements for Basic Case Management.

**2.1.2 Requirements for Complex Case Management were not met**

Complex Case Management services are to be provided by the Primary Care Provider in collaboration with the Plan, and shall include, at a minimum, Basic Case Management services, management of acute or chronic illness, intense coordination of resources, and development of care plan with Primary Care Provider input (*Contract A18, Exhibit A, Attachment 11(2) (B)*). In addition, the Plan "shall develop methods to identify Members who may benefit from complex case management services, using utilization data, Health Information Form (HIF)/Member Evaluation Tool (MET) or other DHCS approved tool for this purpose, clinical data, and any other available data, as well as self and physician referral." (*Contract A18, Exhibit A, Attachment 11(2) (C)*).

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The Plan did not have a Complex Case Management Program. 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. The Plan did not provide any complex case management to eligible Members.

Multiple Plan Providers were interviewed and all reported no knowledge of the Plan's Complex Case Management policies, procedures or services. Some noted that they could identify Members who would benefit from such services. The requirements for Complex Case Management were not met.

### 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 (*Contract A18, Exhibit A, Attachment 11(1)*).

The Plan's Case Management policies and procedures were reviewed for compliance. Per *Policy#: UM-03.03, Care Coordination and Case Management*, the Plan defined Care Coordination/ Case Management as a process directed at coordination, referral, and integration of resources for ill or injured individuals on a case by case basis to facilitate quality of care. The policy did not contain a definition, procedures or processes for Complex Case Management as required by the *Contract Amendment*.

### **RECOMMENDATIONS:**

- 2.1.1 Provide Basic Case Management.
- 2.1.2 Meet all Complex Case Management requirements.
- 2.1.3 Adopt policy and procedures that meet the requirements of the Contract Amendment.

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2.3

### EARLY INTERVENTION SERVICES / DEVELOPMENTAL DISABILITIES

#### Services for Persons with Developmental Disabilities:

- A. Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.
- B. Contractor shall provide all screening, preventive, Medically Necessary, and therapeutic Covered Services to Members with developmental disabilities. Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall monitor and coordinate all medical services and Medically Necessary Outpatient Mental Health Services with the Regional Center staff, including identification of all appropriate services, which need to be provided to the Member.
- C. Services provided under the Home and Community-Based Services (HCBS) waiver programs to persons with developmental disabilities are not covered under this Contract. Contractor shall implement and maintain systems to identify Members with developmental disabilities that may meet the requirements for participation in this waiver and refer these Members to the HCBS waiver program administered by the State Department of Developmental Services (DDS).  
If DDS concurs with the Contractor's assessment of the Member and there is available placement in the waiver program, the Member will receive waiver services while enrolled in the plan. Contractor shall continue to provide all Medically Necessary Covered Services.
- D. Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers as stipulated in Exhibit A, Attachment 12, Provision 2 for the coordination of services for Members with developmental disabilities.

COHS Contract A.11.11

#### Early Intervention Services:

Contractor shall develop and implement systems to identify children under three (3) years of age who may be eligible to receive services from the Early Start Program and refer them to the local Early Start Program .... Contractor shall collaborate with the local Regional Center or local Early Start Program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start Program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start Program, with Primary Care Provider participation.

COHS Contract A.11.12

### **SUMMARY OF FINDINGS:**

#### **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**

The Contract requires the Plan to execute an *MOU* with the local Regional Center for the coordination of services for Members with developmental disabilities (*Contract, Exhibit A, Attachment 11(9) (D)*).

The Plan signed an *MOU* with the local Regional Center/ Early Start to ensure that Members with early start and developmental disabilities receive appropriate care and achieve optimal clinical outcomes. The *MOU* described the responsibilities of the local Regional Center/ Early Start and of the Plan in the delivery of services to the Plan's eligible Members. According to the *MOU*, 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 *MOU* required that this meeting occur at least semi-annually. One of the *MOU* 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.

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**RECOMMENDATION:**

2.3.1 Hold all meetings as required by the MOU.

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2.4

### INITIAL HEALTH ASSESSMENT

#### Provision of Initial Health Assessment:

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

COHS Contract A.10.3.A

Contractor shall make repeated attempts, if necessary, to contact a Member and schedule an IHA.....(as required by Contract)

COHS Contract A.10.3.E

#### Provision of IHAs for Members under Age 21:

- 1) For Members under the age of 18 months, Contractor shall ensure the provision of an IHA within 120 calendar days following the date of enrollment or within the most recent periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two (2) and younger, whichever is less.
- 2) For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.

COHS Contract A.10.5

#### Services for Adults Twenty-One (21) Years of Age and Older:

Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.

COHS Contract A.10.6

### SUMMARY OF FINDINGS:

#### 2.4.1 The Plan did not ensure that IHAs for new Members were completed within 120 calendar days of enrollment

The Plan is required to ensure the provision of an Initial Health Assessment (IHA) in conformance with *CCR, Title 22 § 53910.5 (a) (1)* for each new Member within 120 calendar days following the date of enrollment (*Contract, Exhibit A, Attachment 10(3) (A)*).

The Plan did not ensure that Members receive an IHA within 120 days from enrollment. The method the Plan used to ensure IHA completion was inadequate. The Plan relied on its Providers to access raw Member data; however, most Plan Providers interviewed had no knowledge of the existence of the Member data. One Provider interviewed did manually go through the data to identify new Members, yet took no further steps to schedule an IHA with new Members.

The Plan's methods for monitoring IHA completion were inadequate. Two methods were used: Facility Site Reviews (FSR), which were conducted every three years and an IHA completion rate calculation based on CPT codes. Retrospective review of IHA completion every three years during FSR did not constitute monitoring of IHA completion.

The Plan's methodology to monitor IHA compliance was not adequate. Certain CPT codes were assumed to represent an IHA, but there was no testing of this to ensure its validity. The Plan's methodology for estimating IHA completion rates also excluded Special Members. The Plan has a duty to ensure all Members including Special Members have an IHA.

A verification study of 20 Member records was conducted. Four had no medical records on file and four had missing, incomplete or late IHAs.

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**RECOMMENDATIONS:**

2.4.1 Ensure that new Members receive an IHA within 120 calendar days of enrollment.

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### CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1

#### APPOINTMENT PROCEDURES AND WAITING TIMES

##### **Appointment Procedures:**

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

COHS Contract A.9.3.A

Members must be offered appointments within the following time frames:

c) Non-urgent primary care appointments – within ten (10) business days of request;

COHS Contract A.9.3.A.2

##### **Prenatal Care:**

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

COHS Contract A.9.3.B

##### **Waiting Times:**

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

COHS Contract A.9.3.C

#### **SUMMARY OF FINDINGS:**

##### **3.1.1 The Plan's Procedure for monitoring time to obtain various appointments was not valid**

*Contract, Exhibit A, Attachment 9 (3)(C)* requires the Plan to develop, implement, and maintain a procedure to monitor the time to obtain various types of appointments indicated in *Contract, Exhibit A, Attachment 9 (A)*.

The Plan conducted an Annual Provider Survey in November and December 2013 of 607 contracted Providers to monitor length of time to obtain appointments for urgent care, non-urgent care with PCPs, non-urgent care with Specialists, 24/7 triage services and advanced access. Providers were asked four questions with the option to answer either "yes" or "no". The Plan measured access with a self-reported methodology. 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:

- Several measures of access were self-reported as 100% compliant; by itself, this result casts doubt on the method's validity.
- >25% of all grievances were related to access issues. This finding is discordant with high compliance rates with timely access standards.
- The Plan's CAHPS scores showed Composite "Top Box" scores of 77.9% for Getting Needed Care and Getting Care Quickly. These numbers conflict with the 100% compliance number with timely access standards.

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- The Plan's own Timely Access Research Report contained the statement: "Three-fourths always or usually got an appointment for urgent care when they needed it. The average wait time for urgent care was two days but one in five reported that they usually had to wait more than four days." This statement is again inconsistent with the contention that the self-reported numbers displayed very high compliance in a valid manner.

Plan's Policy#: CP.12, *Timely Access and Network Adequacy Compliance Monitoring*, specified Secret Shopper program as one of the Plan's methods to monitor wait times for appointments, however, it was not conducted during the audit period.

### 3.1.2 No Corrective Action Plan for Providers who are non-compliant with timely access standards

*Contract, Exhibit A, Attachment 9 (3)* requires the Plan to establish acceptable accessibility standards in accordance with *CCR, Title 28, section 1300.67.2.2 (d)(3)* which states plans are required to implement prompt investigative and corrective action for non-compliant Providers with timely access standards to bring its network into compliance; and give advance written notice to the Providers affected by the corrective action that includes a description of the identified deficiencies, and the rationale for the corrective action as also outlined in Plan's Policy #: *CP.12, Timely Access and Network Adequacy Compliance Monitoring*.

When the Plan's method to monitor access standards did identify deficiencies, the Plan did not take the appropriate corrective action. According to the Provider Survey, two Providers were identified to be out of compliance with access in providing urgent care appointments and 24 hours triage services and required corrective action. 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.

### 3.1.3 No monitoring of wait time for first prenatal visit

The Plan is required to monitor appointment waiting times for prenatal care to ensure that the first prenatal visit for a pregnant Member is available within two weeks upon request (*Contract, Exhibit A, Attachment 9 (3)(A),(B) and(C)*).

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. The Plan relied on HEDIS for measuring the timeliness of first trimester (within three months) prenatal care; however this did not account for whether the initial prenatal care appointment was available within the required time frame.

### 3.1.4 No monitoring of wait times at Providers' offices and times for Providers to answer phone and return calls

The Plan is required to monitor waiting times in the Providers' offices, and to answer and return telephone calls *Contract, (Exhibit A, Attachment 9 (3) (c))*. Policy #: *PS.06-01, Timely Access and Member Access to Services and Network Sufficiency* stated Member waiting time in the office to see Plan Provider for a scheduled appointment should not exceed 45 minutes.

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. Grievances were filed due to Members being unable to reach a Provider's office by phone during business hours, and no one returned Members' calls. For instance, a Member called a Provider's office multiple times to schedule an appointment, and to follow-up on an Emergency Room visit with PCP. The phone call went direct to voicemail, and no one returned the Member's calls. As part of our review, Auditors called Provider offices by telephone. Some calls were not answered, while others were answered but placed on hold for long periods. The Plan was aware of the problems reaching Provider offices by phone.

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### 3.1.5 Access grievances not reviewed by the Plan's Quality Committee

The Plan is required to implement and maintain a Member Grievance system in accordance with *CCR, Title 22, section 53858 (e)(3)* which states Member grievances shall be submitted to the Plan's quality assurance committee for review and appropriate action at least quarterly (*Contract, Exhibit A, Attachment 14 (1)*). Per *Policy#: CP.12, Timely Access and Network Adequacy Compliance Monitoring*, when access grievances related to waiting times and scheduling of appointments are identified, they will be reported and reviewed by the Plan's Quality Committee on a quarterly basis.

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.

### 3.1.6 No procedures for follow up on missed appointments in the Plan's Policy

The Plan is required to implement and maintain procedures for follow-up on missed appointments (*Contract, Exhibit A, Attachment 9 (3) (A)* requires).

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.

## **RECOMMENDATIONS:**

- 3.1.1 Develop and implement a valid method to monitor Provider compliance with all access standards.
- 3.1.2 Develop and implement a Corrective Action Plan (CAP) for Providers identified to be out of compliance with timely access standards.
- 3.1.3 Monitor waiting times for the initial prenatal visit and ensure that the first prenatal visit is available within the required time frame.
- 3.1.4 Develop and implement a system to monitor waiting time at Providers' offices, and times for Providers to answer telephone and return calls.
- 3.1.5 Review Access grievances and present this information to the Quality Improvement Committee.
- 3.1.6 Develop and implement policies and procedures to follow-up on missed appointments.

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3.3

### TELEPHONE PROCEDURES / AFTER HOURS CALLS

#### Telephone Procedures:

Contractor shall require providers to maintain a procedure for triaging Members' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.

COHS Contract A.9.3.D

Contractor shall maintain the level of knowledgeable and trained staff sufficient to provide Covered Services to Members and all other services covered under this Contract.

COHS Contract A.13.2.A

#### After Hours Calls:

At a minimum, Contractor shall ensure that a Physician or an appropriate licensed professional under his/her supervision is available for after-hours calls.

COHS Contract A.9.3.F

### SUMMARY OF FINDINGS:

#### 3.3.1 Insufficient Member Services staffing at call center

The Plan is required to maintain sufficient Member Services staff to provide covered services to Members (*Contract, Exhibit A, Attachment 13 (2) (A)*).

A review of the Plan's Member Services call center's operations indicated insufficient staffing as evidenced by the following:

- The Plan acknowledged that in order to meet demand during Member Services Representatives breaks, it had to use Member Services Program Specialists to handle the volume of Member calls.
- In order to alleviate the Member Services Representative shortage, the Plan increased the number of budgeted positions from eight during the audit period to ten positions for 2015.
- Member grievance was filed due to the Member being unable to reach a live person at the Plan, and for being placed on hold for long periods of time.
- The Plan monitors Member calls at the Plan level by ACD (Automated Call Distribution) call activity reports on a weekly basis, which include information on the number of calls received, average speed to answer and abandonment rate. Member Services' ACD reports showed the Plan's call-abandonment rate after 20 seconds increased from 6.7% of calls for the period of 8/1/13 to 12/31/13, to 12% for 1/1/14 to 7/31/14. The abandonment rate doubled during the audit period.
- Weekly ACD call activity reports revealed an increasing number of calls directed to voice mail from 11% for the period of 8/1/13 to 12/31/13 to 18% during 1/1/14 to 7/31/14.

#### 3.3.2 The Plan did not maintain knowledgeable Member Services staff, and did not take corrective action when call monitoring deficiencies were identified

The Plan is required to maintain the level of knowledgeable and trained Member Services staff sufficient to provide covered services to Members and all other services covered under the Contract (*Contract, Exhibit A, Attachment 13 (2) (A)*).

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:

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- Fifteen calls did not meet all criteria including: open/end call appropriately, providing accurate information, documenting calls, offering explanations, and resolutions. This problem was also seen in the Plan's inquiry log records. For example, a Member called the Plan to request reimbursement for out of area urgent care services received. The Member Services Representative told the Member that urgent care was not covered and proceeded to offer possible options to attempt to get the claim paid. However, out-of-area urgent care is a covered service that can be provided by any Provider according to Plan *Policy #: HS-03, Utilization Review and Care Coordination/Case Management Program* and the Plan's *EOC*. The Member Services Representative was unfamiliar with covered services and misinformed the Member.
- Fourteen calls reviewed did not include employee signatures indicating that the reviewer had discussed the issue with the Member Service Representative, or evidence of corrective action. The Plan did not take corrective action to address problems identified by Members Services call monitoring.

### **RECOMMENDATIONS:**

- 3.3.1 Ensure Member Services maintains sufficient staff to provide covered services to Members.
- 3.3.2 Maintain knowledgeable Member Services staff. Take corrective actions when call monitoring deficiencies are identified.

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3.5

**EMERGENCY SERVICE PROVIDERS**

**Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization: (Claims)**

Contractor is responsible for coverage and payment of emergency services and post stabilization care services and must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the plan.

COHS Contract A.8.12.A

Contractor shall pay for Emergency Services received by a Member from non-contracting providers.

COHS Contract A.8.12.C

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 such as laboratory and radiology.

COHS Contract A.8.12.D

For all non-contracting providers, reimbursement by Contractor or by a subcontractor who is at risk for out-of-plan Emergency Services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with provision 4, Claims Processing, above, and 42 USC Section 1396u-2(b)(2)(D).

COHS Contract A.8.12.E

**Claims Processing**

Contractor shall pay all claims submitted by contracting providers in accordance with this provision, unless the contracting provider and Contractor have agreed in writing to an alternate payment schedule.

- A. Contractor shall pay all claims submitted by contracting providers in accordance with this provision....Contractor shall comply with 42 USC Section 1396a(a)(37) and Health and Safety Code Sections 1371 through 1371.39.
- B. Contractor shall pay 90 percent of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities, within 30 days of the date of receipt and 99 percent of all clean claims within 90 days. The date of receipt shall be the date Contractor receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date of the check or other form of payment....

COHS Contract A.8.4

Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR Section 1300.67(g)(1).

COHS Contract A.9.6.A

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).

CCR, Title 28, Section 1300.71(g)

**SUMMARY OF FINDINGS:**

**3.5.1 The Plan did not pay all claims from Providers for emergency services**

The Plan "is responsible for coverage and payment of emergency services...regardless of whether the Provider that furnishes the services has a contract with the Plan" (*Contract, Exhibit A, Attachment 8 (12) (A)*).

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The Plan's Director of Claims stated that regulations do not require the Plan to pay non Medi-Cal or out-of-state Providers. 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. The claim information and remittance advice showed that the Plan had denied these claims for reason code 1500 (Provider Not Payable). The Plan did not comply with the Contract by denying claims for emergency services from out-of-state Providers and non-contracted Providers located in California.

### 3.5.2 The Plan did not forward claims to the appropriate provider within 10 days of receipt

The Plan is required "to forward the claim to the appropriate capitated Provider within ten (10) working days of the receipt of the claim that was incorrectly sent to the Plan" (*CCR, Title 28, §1300.71(b) (2) (A)*).

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. One of the claims reviewed showed that the Plan did not forward a misdirected claim to its delegated entity within the time requirement. The claim was originally denied with reason "1500 Provider Not Payable". Later, when the Provider became an active Medi-Cal Provider, Provider Services submitted a request to reprocess the claim. When the claim was reprocessed, it was deemed a misdirected claim and forwarded. 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.

### 3.5.3 The Plan automatically reduced payment on Emergency Room (ER) claims without obtaining medical documentation

The Plan "may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition" (*Contract, Exhibit A, Attachment 10 (1)*).

The Plan maintained a list of diagnosis codes that would automatically result in full payment of a claim at the Level 5 (99285) rate. When the diagnosis code in a Level 5 claim was not on the list, the payment was automatically reduced to the Level 1 (99281) rate. The Plan did not follow the process as outlined in their Policies and Procedures. *Policy#:CO.02-01* stated that "E&M code 99285 requires documentation and if the diagnosis code did not support, the claim would suspend for medical review." The Remittance Advice contained the explanation by code for the payment reduction and transferred the responsibility to the Provider to submit documentation to appeal the decision. The Plan was not in compliance with the Contract or their Policies and Procedures by automatically reducing payment on many Level 5 claims without suspending them for medical review. Our review identified 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.

### 3.5.4 The Plan did not process complete claims within 45 working days

The Plan is required to "reimburse each complete claim, or portion thereof, whether in state or out of state...no later than 45 working days after the date of receipt of the complete claim by the Plan" (*CCR, Title 28 §1300.71(g)*). The Plan is required to "contest or deny a claim, or portion thereof, by notifying the Provider, in writing, that the claim is contested or denied...within 45 working days after the date of receipt of the claim by the Plan" (*CCR, Title 28 §1300.71(h)*).

Our review showed that 6 of 25 claims were paid or modified after 45 working days. The oldest claim in our review was aged 392 working days before the denial was sent. The Plan did not comply with the requirements in Regulation and *Policy#:CO.02-01, Non-Contracted Emergency Physicians Services – Medi-Cal* by letting claims age longer than 45 working days.

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### 3.5.5 Remittance advices did not contain required denial reasons or identify follow-up information

The Plan is required to disclose the “specific rationale used in determining why the claim was rejected” (CA H&S 1399.55).

Providers that billed the Plan but were identified as not found in the claim system, had their claims denied with reason 1500 (Provider Not Payable). The Plan denied claims via remittance advices that did not specify the rationale for rejecting the claim, what information was lacking to pay the claim, or include information for follow-up or appeal. Although the Plan indicated that it used “Provider Not Found letters” to contact and inform providers, it could not produce any of the requested letters due to being either lost or simply not done. 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.

#### **RECOMMENDATIONS:**

- 3.5.1 Pay for emergency services claims from non-contracted Provider.
- 3.5.2 Forward misdirected claims to the appropriate Provider within 10 working days of receipt of the claim.
- 3.5.3 Pay claims with the CPT code 99285 at the proper rate.
- 3.5.4 Process all claims within 45 working days.
- 3.5.5 Disclose specific denial rationale. Ensure that when claims are denied, the reasons are appropriate. Effectively inform Providers of the Plan’s claims appeal process.

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3.6

### FAMILY PLANNING SERVICES

#### **Non-Contracting Family Planning Providers' Reimbursement**

Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate....

COHS Contract A.8.8

#### **Claims Processing**

Contractor shall pay all claims submitted by contracting providers in accordance with this provision, unless the contracting provider and Contractor have agreed in writing to an alternate payment schedule.

- A. Contractor shall pay all claims submitted by contracting providers in accordance with this provision....Contractor shall comply with 42 USC Section 1396a(a)(37) and Health and Safety Code Sections 1371 through 1371.39.
- B. Contractor shall pay 90 percent of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities, within 30 days of the date of receipt and 99 percent of all clean claims within 90 days. The date of receipt shall be the date Contractor receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date of the check or other form of payment....

COHS Contract A.8.4

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).

CCR, Title 28, Section 1300.71(g)

### **SUMMARY OF FINDINGS:**

#### **3.6.1 Remittance advices did not contain required denial reasons or identify follow-up information**

The Plan is required to disclose the "specific rationale used in determining why the claim was rejected" (CA H&S § 1399.55).

On two claims reviewed, the actual denial reason was different from the stated denial reason. One stated the denial reason 8004 (Procedure code not covered), while the other had no reason at all. For both claims the actual reason for denial was "lack of NDC number". Both remittance advices did not specify what was lacking, what additional documentation was needed to pay the claim, or include information for Providers to follow-up on or appeal. 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.

Our review of claims showed that 7 of 25 were improperly denied without review instead of being paid or held for documentation review. Four of 25 claims were denied due to "CMS regulations". The Plan improperly denied claims due to a flaw in their claims system. One claim was denied because an E&M code was billed with a surgical procedure code. However, since the Plan did not request documentation, the Plan could not demonstrate that the denial of either code was appropriate.

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**3.6.2 Systemic problems prevented the Plan from processing all claims within 45 working days**

The Plan is required to “reimburse each complete claim, or portion thereof, whether in state or out of state...no later than 45 working days after the date of receipt of the complete claim by the Plan” (*CCR, Title 28§1300.71(g)*).

Our review of claims showed that 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.

**RECOMMENDATIONS:**

- 3.6.1 Disclose specific denial rationale. Ensure that when claims are denied, the reasons are appropriate. Effectively inform Providers of the Plan’s claims appeal process.
- 3.6.2 Process all claims within 45 working days.

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3.7

### ACCESS TO PHARMACEUTICAL SERVICES

#### Pharmaceutical Services and Prescribed Drugs:

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

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

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

#### SUMMARY OF FINDINGS:

##### 3.7.1 **The Plan did not monitor Emergency Departments to ensure Members have access to a 72-hour supply of drugs in emergency situations**

The Plan is required to ensure contracted Emergency Departments have written policies and procedures or specific language in-network hospital subcontracts that provide a minimum of 72-hour supply of a covered outpatient drug in an emergency situation (*Contract, Exhibit A, Attachment 10 (8)(F)(1)(a)*). Plan Policy#: *HS-11: Oversight of Emergency Department's Methods for Ensuring Adequate Dispensing of Drugs* states that all Emergency Departments (ED) at contracted hospitals or medical centers shall have a policy and procedure to provide adequate medication (72-hour supply) in emergency situations until the Member can reasonably be expected to have a prescription filled.

The Plan's Pharmacy Director acknowledged the Plan had no system to monitor access to prescribed medications in emergency situations. The Plan did not monitor any emergency departments to ensure Members have access to sufficient supply of emergency medications. Plan's Policy#: *HS-11: Oversight of Emergency Department's Methods for Ensuring Adequate Dispensing of Drugs* states that the Plan would ensure Members have appropriate access to ED discharge medications by conducting these monitoring activities.

- The Plan would randomly select contracted hospital-based EDs on a periodic basis to submit a statement that they have a policy and procedure which ensures Members who receive emergency services are provided sufficient quantity of drugs to last until they can reasonably be expected to have a prescription filled. EDs that did not maintain such a policy and procedure would be required to complete a corrective action plan.
- The Plan would perform audits of the EDs with respect to these policies and procedures.
- The ED policy and procedure should have an auditable method which tracks the provision of medications.

Although the Plan had policies and procedures to monitor that EDs dispense an adequate supply of drugs in an emergency, none of these monitoring procedures were performed during the audit period. The Plan confirmed that it did not require EDs to provide a minimum of 72-hour supply of emergency medication. The Plan's monitoring policy was not implemented.

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**3.7.2 The Pharmacy and Therapeutics Committee did not review and update formulary at the required frequency**

The Plan is required to implement and maintain a process to ensure that its formulary is reviewed and updated, no less than quarterly, by the Plan's Pharmacy and Therapeutics (P&T) Committee (*Contract, Exhibit A, Attachment 10 (8)(F)(3)*).

The Plan's Pharmacy & Therapeutics (P&T) Committee oversaw the Plan's pharmacy benefits and process. The committee reviewed and evaluated the Plan's formulary management, evaluated policies and procedures pertaining to pharmacy practices, and identified problems and issues for the attention of the Commission and the Plan's staff. Plan's *Policy#*: *HPSM-Medi-Cal Drug Formulary Review Process* indicated that the Plan's P&T Committee meetings would occur six times per year. 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.

**RECOMMENDATIONS:**

- 3.7.1 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.
- 3.7.2 Ensure Pharmacy & Therapeutics (P&T) Committee meets to review and update formulary in accordance with the frequency requirements.

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**CATEGORY 4 – MEMBER’S RIGHTS**

**4.1**

**GRIEVANCE SYSTEM**

**Member Grievance System and Oversight:**

Contractor shall implement and maintain a Member Grievance system in accordance with Title 28 CCR Section 1300.68 (except Subdivision 1300.68(c)(g) and (h)), 1300.68.01(except Subdivision 1300.68.01(b) and (c)), Title 22 CCR Section 53858, and 42 CFR 438.420(a)(b) and (c). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member’s health condition requires, within 30 calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written member notice.  
COHS Contract A.14.1

Contractor shall implement and maintain procedures...to monitor the Member’s Grievance system and the expedited review of grievances required under Title 28 CCR Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858.... (as required by Contract)  
COHS Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any sub-contracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).  
COHS Contract A.14.3.A

**SUMMARY OF FINDINGS:**

The Plan received grievances from Members primarily through the Member Services’ call line. Member Services (MS) representatives handled call intake and entered call information into the Plan’s managed care transaction system. Grievance comments were imported into the grievance and appeals electronic system twice daily.

**4.1.1 Improper identification and reporting of grievances**

The Plan is required to establish and maintain written procedures for submittal, processing and resolution of all grievances and complaints (*CCR, Title 22, § 53858*). A grievance is defined as “a written or oral expression of dissatisfaction regarding the Plan and/or Provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee’s representative. Where the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance”. Complaint is the same as grievance (*Contract, Exhibit E, Attachment 1 and CCR, Title 28, §1300.68(a) (1) (2) and the Plan’s EOC (p.5)*).

The Plan’s grievance system did not capture all complaints and expressions of dissatisfaction regarding the Plan and Providers. The Plan received grievances primarily through the Member Services’ call line. Members frequently voiced complaints and dissatisfaction via inquiry calls to the Member Services Department. These complaints were not identified as a grievance unless the Member explicitly stated “I want to file a grievance”.

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The Plan received a total of 47,183 inquiries during the audit period but classified only 131 as grievances. The Member Services Manager stated that a Member Services Grievance and Appeal Guide was used to decide on whether a call was a grievance. The guide instructed Member Services representatives to listen for key words such as "I'm upset/angry". The inquiry call log had 154 instances in which Members were "upset" but these were not classified as grievances. For example a Member was upset and threatened to report the incident to a Congressional Representative before disconnecting. This Member's expression of dissatisfaction was not captured nor did the Member Services Representative offer to file a grievance on the Member's behalf.

Approximately 20,996 of the 47,183 inquiries were requests for a change of PCP or for PCP selection. The Plan did not have a mechanism to review and determine if the changes of PCP were a grievance since the reasons for the request were not identified.

The Plan did not monitor or conduct any internal auditing of the inquiry call log to ensure that potential systemic issues and grievances were not overlooked. The Plan was not in compliance with the requirements for grievance identification.

### 4.1.2 Lack of clinical oversight on grievance classification

The Plan is required to implement and maintain procedures to monitor the Member's Grievance System and the expedited review of grievances (*Contract, Exhibit A, Attachment 14(2)*). The Plan is required to ensure that grievances submitted are reported to the appropriate level i.e. medical issues versus health care delivery issues and resolved by a health care professional with appropriate clinical expertise (*Contract, Exhibit A, Attachment 14(2) (C)*). The Plan is required to have procedures to ensure participation of individuals with authority to require corrective action. Grievances related to Medical quality of care issues should be referred to the Medical Director (*Contract, Exhibit A, Attachment 14 (D)*).

No oversight was conducted by clinical personnel to ensure proper identification of clinical/quality of care grievances. Initially, all pending grievances were reviewed by the Staff Grievance and Appeals Committee (SGAC) but its focus, later in the audit period, changed to the review of complex grievances only. Identified grievances were first classified as clinical versus administrative by an Administrative Assistant, a non-clinical employee who assigned the grievance cases to the Grievance Coordinators. Grievance Coordinators routed all cases classified as quality of care to an Associate Medical Director for review. All other grievances were handled by the Grievance Coordinators, who were non-clinical employees. The Plan was not in compliance with the requirements for grievance monitoring.

### 4.1.3 Time frames exceeded for grievance notification and resolution

The Plan is required to resolve each grievance and provide notice to the Member as quickly as the Member's health condition requires, within 30 calendar days from receipt. The Plan is required to send a written acknowledgment notice to the Member within five calendar from receipt and a written resolution within 30 calendar days of receipt (*Contract A18, Exhibit A, Attachment 14 (1) and (2) (A) and CCR, Title 28 § 1300.68(d) (1) (3)*).

The Plan exceeded the time frame for notification and resolution of grievances. 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 after receipt. The Plan was not in compliance with the requirements for grievance notification and resolution time frames.

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### 4.1.4 **Grievance status notification letters not sent to Members when a resolution was not reached within 30 days**

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

The Plan 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. The Plan was not in compliance with the requirements for grievance status notification.

### 4.1.5 **Time frames exceeded for expedited grievance resolution**

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

The Plan exceeded the time frame for expedited grievance resolution. Seven of the 80 grievances reviewed were classified as expedited grievances. Two of seven expedited grievances were not processed within three calendar days. The Plan was not in compliance with the requirements for expedited grievance processing time frames.

### 4.1.6 **Acknowledgment and resolution letters not translated to the Plan's threshold language**

The Plan is required to fully translate written informing materials, including but not limited to grievance acknowledgment and resolution letters. (*Contract, Exhibit A, Attachment 9 (13) (C) (2)* and *CCR, Title 28, §1300.68(b) (3)*).

The Plan did not translate grievance acknowledgment and resolution letters to its threshold language. 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. The Plan was not in compliance with the requirements for translation of written materials.

### 4.1.7 **Grievance resolution did not address all complaints or did not appropriately address the complaint**

The Plan is required to send a written resolution to the Member that contained a clear and concise explanation of the Plan's decision (*CCR, Title 28 §1300.68 (d) (3)*).

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. Following were two examples:

- 1) Sample #39- A Member complained that: 1) Provider was not listening to the medical issues. 2) Member had to wait 2 days to pick up the medication prescribed during the visit. 3) Member was given the wrong medication. 4) Member was unable to call the clinic in question. 5) Staff at the clinic was unprofessional. 6) Member felt discriminated against. The resolution letter stated that the Provider confirmed that the wait time for the medication was correct. In order to resolve the problem, the Provider offered the Member an appointment at the clinic but the Member declined. The Member was assigned to a new Provider.

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The resolution letter did not address the Member's other numerous complaints. There was no Plan request for medical records and the Grievance Coordinator did not contact the PCP Provider to verify whether the Member's complaints were valid. There were no records of the Member's allegations of discrimination being evaluated by the Plan's Director of Compliance and Regulatory Affairs or that the allegation was forwarded elsewhere as stated in the Plan's policy (*Policy#: GA-07, Member Grievance Procedure for Non-Medicare Lines of Business, paragraph 11.5*).

- 2) Sample #52- A Special Member (a Member not yet paneled to a PCP Provider) was denied an annual health assessment because the Member was not assigned to the Provider for the date of service and therefore the Provider would not receive the annual pay for performance incentive normally paid to assigned Providers. According to Provider's office manager, this was "the office's policy". The resolution letter stated that the Provider was in his right not to conduct a physical exam given that it was not an emergency service. The Member could schedule an appointment with the Provider the following month when the Member would not be a "Special Member" and Provider would then qualify for the pay for performance reimbursement.

This response was not in compliance with *Contract, Exhibit A, Attachment 1 (5)*, which states that "the Plan shall ensure that medical decisions, including those by subcontractors and rendering Providers, are not unduly influenced by fiscal and administrative management". This Provider's medical decisions were influenced by the incentive given by the Plan and the Plan accepted this Provider's deferral of an annual health assessment. Case notes indicated that this specific Provider was particular about "Special Members" and did not wish to see Special Members.

#### 4.1.8 The Plan did not specify whether resolved grievances were in favor of the Member or the Plan

The Plan is required to monitor the number of grievances received and resolved and whether the grievance was resolved in favor of the Member or the Plan as per *CCR, Title 28 § 1300.68 (e) (1)*.

The Plan did not consistently specify whether a resolved grievance was in favor of the Member or the Plan, with two examples being:

- 1) Sample #10- A Member complained that it took two months to get an appointment with Provider only to be told that Member's appointment was not on their books. The resolution letter stated that Provider had been busy and had given the Member the earliest appointment available. If the Member had requested an urgent appointment they would have accommodated the request. This grievance was classified as "favorable".
- 2) Sample #33- A Member complained that a referral authorization form (RAF) had been faxed to the Plan several times but never approved. The resolution letter stated that the RAF had been processed and approved. This grievance was classified as "favorable".

The Plan was not in compliance with requirements for specifying whether a resolved grievance was in favor of the Member or the Plan.

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### 4.1.9 Grievance data was not reported, tracked or appropriately monitored

The Plan is required to track and monitor grievances received and to have a procedure for systematic aggregation and analysis of the grievance data for Quality Improvement (*CCR, Title 28 § (e) and Contract Exhibit A, Attachment 14 (2) (B)*). The Plan is required to submit records of grievances to the Quality Assessment and Improvement Committee (QAIC) for review at least on a quarterly basis, and grievance records to the governing body for review periodically. This review should be thoroughly documented (*CCR, Title 22 § 53858(e) (3) and CCR, Title 28 § 1300.68(b) (5)*). The Plan is also required to have procedures to ensure the participation of individuals with authority to require corrective action. Grievances related to Medical quality of care issues should be referred to the Medical Director (*Contract, Exhibit A, Attachment 14 (E)*).

Plan Policy #: *GA-07: Member Grievance Procedure for Non-Medicare Lines of Business* requires that as part of the Plan's internal grievance policy, grievances should be reviewed by the Staff Grievance and Appeals Committee (SGAC). The SGAC reported to the Quality Management Oversight Committee (QMOC), which oversaw program activities. The QMOC, in turn, reported to the San Mateo Health Commission.

The Plan did not comply with requirements for grievance records submissions and monitoring of the grievance process. 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. There were no records or evidence of a review or discussion about grievances during the SMHC meetings or that grievance information was moved from the consent agenda to the regular agenda. Although two commissioners attended the Advisory committee meetings during the audit period, it does not satisfy the requirement that the Plan's governing body reviews grievance records.

There was no evidence that grievance data related to various departments of the Plan (cultural and linguistic, pharmacy and access) 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. The Plan was not in compliance with the requirements for grievance monitoring and reporting for quality improvement.

### 4.1.10 The Plan did not have a grievance form

The Plan is required to provide a grievance form to Members directly or by mail upon request and ensure that Members are given reasonable assistance in completing forms and other procedural steps. The Plan is required to have grievance forms and a description of the grievance procedure at each facility of the Plan, on the Plan's website and at each contracting Provider's office or facility (*Contract A18, Exhibit A, Attachment 14 (2) (B), CCR, Title 22 §53858 (c) and CCR, Title 28 §1300.68(b) (7)*).

The Plan did not have a grievance form. 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. The Plan was not in compliance with the grievance form accessibility requirements.

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### 4.1.11 The Plan's policy did not reflect the actual grievance process

The Plan is required to implement and maintain procedures to monitor the Member Grievance System and the expedited review of grievances (*Contract, Exhibit A, Attachment 14(2)*).

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:

*Policy #: GA-07, paragraph 1.3.2:* The SGAC reported to the QMOC which oversaw program activities. There was no evidence that the QMOC had any meetings during the audit period. The Plan did not have any meeting minutes for the committee and the QMOC was disbanded in December 2013.

*Policy #: GA-07, paragraph 2.2.6:* Member service representative or grievance and appeals coordinator may assist a Member in completing the grievance form. The Plan did not have a grievance form during the audit period.

*Policy #: GA-07, paragraph 3.1.4:* Access to Member Grievance Process shall be ensured by making grievance forms and a description of the grievance process available at HPSM's office site, on HPSM's website and at each contracted Provider facility. The Plan did not have a grievance form and did not have it available at the Plan's office site, Plan's website or at each contracted Provider's facility.

*Policy #: GA-07, 6.2:* Expedited grievances were reconsiderations (appeals) and were processed through the Member appeals policy and procedure (*Policy #: GA-08, Member Appeal Procedure-Non Medicare Lines of Business*). According to the grievance manager, this policy did not reflect the Plan's actual process for expedited grievances, as expedited grievances were not reconsiderations (appeals) and were not processed through the Member appeals policy and procedure.

### 4.1.12 Lack of grievance and appeal system oversight by the designated Plan Grievance Officer

The Plan has obligations to ensure that an officer of the Plan shall be designated as having primary responsibility for the Plan's grievance system and continuously review the operation of the grievance system to identify any emergent patterns of grievances. This system shall include the reporting procedures in order to improve the Plan's policies and procedures (*CCR, Title 28 §1300.68(b)(1)*).

For most of the audit period, the designated Plan Grievance Officer was the Director of Compliance and Regulatory Affairs. The Director of Member Services assumed this role late in the audit period. There were numerous problems with the grievance system, as evidenced by the above findings numbers 4.1.1 through 4.1.11. 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. The lack of continuous review and oversight of the grievance system by a designated Plan Grievance Officer was a factor in these issues not being identified and corrected.

The Plan was not in compliance with contract requirements ensuring that the designated Plan Grievance Officer has primary responsibility for the grievance system and for continuous review of the system to identify emergent patterns of grievances.

## **RECOMMENDATIONS:**

- 4.1.1 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.

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- 4.1.2 Develop and implement a process for monitoring and reviewing grievances designated as non-clinical to ensure quality of care issues are not missed.
- 4.1.3 Send grievance acknowledgment letters to Members within the five calendar days and resolution letters within 30 calendar days. Resolve grievances within 30 calendar days.
- 4.1.4 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.
- 4.1.5 Send expedited grievance acknowledgment and resolution letters to Members within the required time frames.
- 4.1.6 Send acknowledgment and resolution letters to Members that are fully translated to the Plan's threshold language.
- 4.1.7 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.
- 4.1.8 Determine whether grievances classified as "favorable" are classified in favor of the Member or the Plan. Consistently apply that terminology.
- 4.1.9 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.
- 4.1.10 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.
- 4.1.11 Ensure that the Plan's grievance policy reflects and is consistent with the Plan's actual grievance process.
- 4.1.12 Require the designated Plan Grievance Officer to continuously review the operation of the grievance system in order to identify any emergent patterns of grievances.

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4.2

### CULTURAL AND LINGUISTIC SERVICES

#### **Cultural and Linguistic Services Program:**

Contractor shall have a Cultural and Linguistic Services Program that monitors, evaluates, and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Contractor shall review and update their cultural and linguistic services consistent with the requirements... (As required by the Contract).

COHS Contract A.9.12

Contractor shall assess, identify and track the linguistic capability of interpreters or bilingual employees and contracted staff (clinical and non-clinical).

COHS Contract A.9.12.B

Contractor shall provide cultural competency, sensitivity, or diversity training for staff, providers and subcontractors at key points of contact.

COHS Contract A.9.12.D

#### **Linguistic Services:**

Contractor shall ensure compliance with Title VI of the Civil Rights Act of 1964 and any implementing regulations (42 USC Section 2000d and 45 CFR Part 80) that prohibits recipients of federal financial assistance from discriminating against persons based on race, color, religion, or national origin.

COHS Contract A.9.11

Contractor shall comply with Title 22 CCR Section 53853(c) and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries receive 24-hour oral interpreter services at all key points of contact...either through interpreters or telephone language services.

COHS Contract A.9.13.B

#### **Types of Linguistic Services:**

Contractor shall provide, at minimum, the following linguistic services at no cost to Medi-Cal Members... (as required by Contract).

- 1) Oral Interpreters, signers, or bilingual providers and provider staff at all key points of contact. These services shall be provided to in all languages spoken by all Medi-Cal beneficiaries and not limited to those that speak the threshold or concentration standards languages.
- 2) Fully translated written informing materials... (as required by Contract).
- 3) Referrals to culturally and linguistically appropriate community service programs.
- 4) Telecommunications Device for the Deaf (TDD)

COHS Contract A.9.13.C

#### **Key Points of Contact Include:**

- 1) Medical care settings: telephone, advice and urgent care transactions, and outpatient encounters with health care providers including pharmacists.
- 2) Non-medical care setting: Member services, orientations, and appointment scheduling.

COHS Contract A.9.13.E

### **SUMMARY OF FINDINGS:**

#### **4.2.1 Lack of access to interpreter services**

The Plan is required to "ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries receive 24-hour interpreter services at all key points of contact" (*Contract, Exhibit A, Attachment 9 (13) (B)*).

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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.

### 4.2.2 Translated material not accessible through the Plan's website

The Contract requires that the Plan "shall ensure equal access to health care services for its Members without regards to a Member's proficiency in the English language" (*Contract, Exhibit A, Attachment 9 (13) (A)*).

The Plan was responsible for translating all Member materials into its threshold language, Spanish. The Plan's website did not have navigation options for any other language, or direct access to the documents translated into Spanish. 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.

### 4.2.3 The Plan did not use GNA findings to influence C&L initiatives

The Plan "shall demonstrate upon request by the State, how the Group Needs Assessment (GNA) findings and conclusions are utilized by the plan to Provide contractually required cultural and linguistic services for Members" (*Contract, Exhibit A, Attachment 9 (12) (C)*).

The Plan did not utilize findings from the 2011 GNA to guide initiatives for C&L improvement. The Plan created the 2013 QI Work Plan initiatives based on the Contract. The 2011 GNA findings recommended that the Plan promote translated health education resources. The Plan did not include this finding as part of their initiatives in the QI Work Plan for 2013 or 2014.

### 4.2.4 C&L Committee did not implement initiatives based on the QI Work Plan

The Contract requires that the Plan "have a Cultural and Linguistic Services Program that monitors, evaluates, and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services" (*Contract, Exhibit A, Attachment 9 (12)*).

The Plan did not take effective action to improve their C&L program. 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. The 2013 QI Work Plan contained the same initiatives between quarters. An example of an identified area where the Plan failed to improve on, was the use of family members or friends as interpreters.

### 4.2.5 The Plan did not have a consistent system to assess bilingual employees

The Plan is required to "assess, identify and track the linguistic capability of interpreters or bilingual employees" (*Contract, Exhibit A, Attachment 9 (12) (B)*). *MMCD Policy Letter 99-03* stated guidelines for ensuring bilingual proficiency in nonmedical and medical settings included "precisely explain nonclinical consent forms...should be fluent in medical terminology in both languages" (*MMCD Policy Letter 99-03*).

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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. The template was not specific about content and did not address dialogue related to medical and nonmedical key points of contact. The content of the assessment was decided by the individual assessor.

### **RECOMMENDATIONS:**

- 4.2.1 Provide 24 hour oral-interpreter services at all key points of contact.
- 4.2.2 Translate the Plan's website to the threshold language.
- 4.2.3 Use the GNA survey findings to guide initiatives of the C&L Committee.
- 4.2.4 Take effective action to address any needed improvement in C&L services.
- 4.2.5 Implement a consistent, standardized and effective system to assess the linguistic capability of bilingual employees.

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4.3

### CONFIDENTIALITY RIGHTS

#### Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:

##### C. Responsibilities of Business Associate.

2. **Safeguards.** To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316....(as required by Contract)

- J. **Breaches and Security Incidents.** During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1. **Notice to DHCS.** (1) To notify DHCS immediately by telephone call plus email or fax upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. (2) To notify DHCS within 24 hours by email or fax of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate....
2. **Investigation and Investigation Report.** To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:
3. **Complete Report.** To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure....

COHS Contract G.III.C, J

#### **SUMMARY OF FINDINGS:**

##### **4.3.1 The Plan's breach and security incident reporting process allowed certain unauthorized PHI disclosures to circumvent DHCS reporting**

The Plan must "notify immediately by telephone call plus e-mail or fax upon the discovery of breach of security of PHI in computerized form if the PHI was, or is reasonably to have been, acquired by an unauthorized person; or within 24 hours by e-mail or fax of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of this Contract" (*Contract, Exhibit G, 3(H)*).

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.

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**RECOMMENDATIONS:**

4.3.1 Report all breaches and security incidents to DHCS within the required time frames.

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**CATEGORY 5 – QUALITY MANAGEMENT**

5.1

**QUALITY IMPROVEMENT SYSTEM**

**General Requirements:**

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28 CCR Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider.

COHS Contract A.4.1

**Written Description:**

Contractor shall implement and maintain a written description of its QIS...(as required by Contract)

COHS Contract A.4.7.A-1

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

COHS Contract A.4.2

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

- A. Approves the overall QIS and the annual report of the QIS.
- B. Appoints an accountable entity or entities within Contractor's organization to provide oversight of the QIS.
- C. Routinely receives written progress reports from the quality improvement committee describing actions taken, progress in meeting QIS objectives, and improvements made.
- D. Directs the operational QIS to be modified on an ongoing basis, and tracks all review findings for follow-up.

COHS Contract A.4.3.A-D

**Provider Participation:** Contractor shall ensure that contracting Physicians and other providers from the community shall be involved as an integral part of the QIS. Contractor shall maintain and implement appropriate procedures to keep contracting providers informed of the written QIS, its activities, and outcomes.

COHS Contract A.4.5

**SUMMARY OF FINDINGS:**

**5.1.1 No mechanism to detect and correct under-service by at-risk Providers**

The Plan is required to have a Quality Improvement System (QIS) in accordance with standards in *CCR, Title 28 §1300.70* and *Contract, Exhibit A, Attachment 4 (1)*. A plan that has capitation or risk-sharing contracts must have a mechanism to detect and correct under-service by an at-risk Provider (*CCR, Title 28 §1300.70*).

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. The Plan was not in compliance with the requirement of a QIS in accordance with *CCR, Title 28 §1300.70*.

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### 5.1.2 Governing Body not directing operational QIS

The Plan's Governing Body is required to direct the operational QIS to be modified on an ongoing basis (*Contract, Exhibit A, Attachment 4 (3) (D)*).

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. The Plan did not meet the Contract's required responsibilities regarding the Governing Body.

### 5.1.3 QI Committee fails to meet at least quarterly to follow-up on findings and required actions; members fail to attend

The Plan is required to have a QI Committee that meets at least quarterly, keeps written minutes, demonstrates follow-up and action and has participation by the Medical Director and contracted Providers (*Contract, Exhibit A, Attachment 4 (4)*).

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. The Plan did not comply with requirements for QI Committee meetings, minutes or participation by the Medical Director or contracting physicians.

### 5.1.4 No QI mechanism to evaluate and improve access

The Plan is required to continuously review, evaluate, and improve access to and availability of services. (*Contract, Exhibit A, Attachment 4 (7) (G)*).

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. The Plan's QIS failed to address access to and availability of services as required by the Contract.

### 5.1.5 No QI Involvement in service issues

The Plan's QIS must address service elements (*CCR, Title 28 §1300.70(a) (3)*).

The Plan's QIS was primarily directed at clinical measures. Service issues were addressed by individual Departments within the Plan without involvement of QI. The Plan's QIS did not address service elements.

## **RECOMMENDATIONS:**

- 5.1.1 Develop internal controls and a mechanism to detect and correct under-service by at-risk Providers.
- 5.1.2 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.
- 5.1.3 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.

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- 5.1.4 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.
- 5.1.5 Expand the current QIS to include elements of service as well as clinical efforts.

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### 5.2

### PROVIDER QUALIFICATIONS

#### **Credentialing and Re-credentialing:**

Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of Physicians including Primary Care Physicians and specialists in accordance with the MMCD, Credentialing and Recredentialing Policy Letter, MMCD Policy Letter 02-03. Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

COHS Contract A.4.12

#### **Provider Qualifications:**

All providers of Covered Services, including physicians and specialists, must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered and have a valid National Provider Identifier (NPI) number.

COHS Contract A.4.12.A

#### **Delegated Credentialing:**

Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with Provision 6. Delegation of Quality Improvement Activities...

COHS Contract A.4.12.C

#### **Disciplinary Actions:**

Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider appeal process.

COHS Contract A.4.12.E

#### **Medi-Cal and Medicare Provider Status:**

The Contractor will verify that their subcontracted providers, including physicians and specialists, have not been terminated as Medi-Cal or Medicare providers or have not been placed on the Suspended and Ineligible Provider list. Terminated providers in either Medicare or Medi-Cal/Medicaid or on the Suspended and Ineligible Provider list, cannot participate in the Contractor's provider network.

COHS Contract A.4.12.F

### **SUMMARY OF FINDINGS:**

#### **5.2.1 No credentialing and re-credentialing delegation agreements with two subcontractors**

The Plan may delegate credentialing and re-credentialing activities, and if delegated, shall comply with Provision 6, Delegation of Quality Improvement Activities (*Contract, Exhibit A, Attachment 4(12) (B)*). The Plan is accountable for all quality improvement functions and responsibilities, such as utilization management, credentialing and site review, that are delegated to subcontractors. If the Plan delegates quality improvement functions, the Plan and subcontractors shall include in their Subcontract the specific delegated functions and activities of the Contractor and subcontractor (*Contract, Exhibit A, Attachment 4(6) (A)*).

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. The Plan was not in compliance with delegation agreement requirements.

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### 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**

The Plan must ensure that contracts with their subcontractors (delegated entities) include actions and remedies should the contracts be terminated or agreements and terms not fulfilled by those entities (*Contract, Exhibit A, attachment 4(6) (A) (4)*).

Two delegation agreements did not include clauses for actions and remedies for subcontract termination or breach of subcontract agreements and terms. The Plan was not in compliance with contract language in regards to remedies in the event of termination of agreements or breach of terms and agreements in the subcontracts of delegated entities.

### 5.2.3 **No annual oversight, monitoring and evaluation of three subcontractors**

The Plan must ensure that there are oversight, monitoring and evaluation processes and subcontractor's agreement to such processes (*Contract, Exhibit A, Attachment 4(6) (A) (2)*).

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. The Plan was not in compliance with annual oversight, monitoring and evaluation for three of their subcontractors.

## **RECOMMENDATIONS:**

- 5.2.1 Execute delegation agreements for all entities with delegated credentialing and re-credentialing activities.
- 5.2.2 Include clauses for agreement termination and remedies for non-fulfillment of the agreement terms in delegation subcontracts.
- 5.2.3 Perform annual oversight, monitoring and evaluation of credentialing and re-credentialing activities on all delegated entities.

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**CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY**

**6.1**

**MEDICAL DIRECTOR**

**Medical Director:**

Contractor shall maintain a full time Physician as Medical Director whose responsibilities shall include, but not be limited to, the following:

- A. Ensuring that medical decisions are:
  - 1) Rendered by qualified medical personnel.
  - 2) Are not unduly influenced by fiscal or administrative management considerations.
- B. Ensuring that the medical care provided meets the standards for acceptable medical care.
- C. Ensuring that medical protocols and Standards of Conduct for plan medical personnel are followed.
- D. Developing and implementing medical policy.
- E. Resolve grievances related to medical quality of care. For purposes of this provision, the resolution of grievances related to medical quality of care may be by the Medical Director's physician designee.
- F. Have a role in the implementation of Quality Improvement activities.
- G. Actively participate in the functioning of the Contractor's grievance procedures as specified in Exhibit A, Attachment 14, Member Grievance System.

COHS Contract A.1.6

**SUMMARY OF FINDINGS:**

**6.1.1 Medical Director did not ensure standards for acceptable medical care were met**

The Plan's Medical Director has obligations to ensure that medical care provided to Members met the standards for acceptable medical care (*Contract, Exhibit A, Attachment 1,(6)(B) and CCR, Title 22, §53246,(a)(2)*).

The Plan's Medical Director did not ensure standards for acceptable medical care were met. 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. A significant dermatologic diagnosis was made without an abnormal skin exam recorded. The Medical Director did not communicate with the Provider regarding the complaints and did not investigate the inconsistency of a normal skin exam with a recorded dermatologic diagnosis. The resolution letter to the Member mentioned no quality of care concerns. The investigation of the Provider and inspection of the medical record was incomplete. The Medical Director did not ensure provision of acceptable medical care and was not in compliance with acceptable medical care standards.

**6.1.2 Medical Director did not fully investigate or resolve quality of care grievances**

The Plan Medical Director had obligations to resolve grievances related to medical quality of care (*Contract, Exhibit A, Attachment 1(6) (E) and CCR, Title 22 § 53246(a) (5)*).

The Plan's Medical Director designee did not completely evaluate all facts pertaining to the resolution of a medical quality of care grievance. In the grievance noted in 6.1.1, numerous Member clinical complaints were not supported by the medical record. The inconsistency in the medical record of a normal skin exam with a dermatologic diagnosis was not noted or documented. The grievance was not fully resolved, as the Medical Director designee did not contact the Provider to discuss the multiple unsubstantiated complaints and discrepancy in skin exam and documentation. Instead there was deemed to be no quality issues and the Member was simply changed to a new Provider. The Plan did not meet obligations for the Medical Director designee to resolve grievances related to medical quality of care.

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### 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**

The Medical Director should actively participate in the functioning of the Plan grievance procedures (*Contract, Exhibit A, Attachment 1(6) (G) and CCR, Title 22, § 53246(6)*). The Medical Director should have a role in the implementation of Plan quality improvement activities (*Contract, Exhibit A, Attachment 1(6) (F)*).

The Plan's Medical Director did not actively participate in grievance procedures or the implementation of quality improvement activities. The Medical Director's role in grievances and quality improvement includes accountability for integration of grievance data into Plan quality improvement activities. The grievance system failed to capture and identify all grievances. 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. These findings indicate insufficient Medical Director participation in the grievance system and integration of grievance data into quality improvement activities.

#### **RECOMMENDATIONS:**

- 6.1.1 Enforce standards of acceptable medical care throughout the Plan.
- 6.1.2 Resolve medical quality of care grievances only after complete investigation by the Medical Director.
- 6.1.3 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.

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6.2

### MEDICAL DECISIONS

#### Medical Decisions:

Contractor shall ensure that medical decisions, including those by subcontractors and rendering providers, are not unduly influenced by fiscal and administrative management.

COHS Contract A.1.5

#### SUMMARY OF FINDINGS:

##### 6.2.1 The Plan did not have internal controls to ensure that medical decisions were not influenced by fiscal or administrative management considerations

The Plan must ensure that medical decisions, including those by subcontractors and rendering Providers, are not unduly influenced by fiscal or administrative management (*Contract, Exhibit A, Attachment (5)*). The Plan Medical Director must ensure that medical decision making is not unduly influenced by fiscal or administrative management considerations (*Contract, Exhibit A, Attachment 1(6) (A) (2)*).

The Plan did not have internal controls to ensure that medical decisions were not influenced by the Plan's financial reimbursement methods. 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. Field visits to PCP offices disclosed that providers did not maintain the capacity for minor procedures, such as wart removal, instead referred all such patients to dermatology. The Plan Medical Director shared that an ENT (Ear, Nose and Throat) specialist had complained about being overwhelmed with referrals for earwax removal. Both procedures are part of the standard primary care scope of practice, and are specified in the Plan capitated PCP contract (*Attachment C of the Primary Care Physician Contract, Scope of Capitated Services*). The Plan did not comply with requirements that medical decisions by rendering Providers were free from the influence of fiscal and administrative concerns.

##### 6.2.2 Barriers to annual health assessments and urgent care visits due to fiscal considerations

The Plan must ensure that medical decisions, including those by subcontractors and rendering Providers, are not unduly influenced by fiscal or administrative management (*Contract, Exhibit A, Attachment 1, (5)*). The Plan Medical Director must ensure that medical decision making is not unduly influenced by fiscal or administrative management considerations (*Contract, Exhibit A, Attachment 1(6) (A) (2)*).

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. A grievance was filed by a member who was not able to get an annual health assessment. The grievance investigation revealed that the provider had a policy of not seeing Special Members for an annual health assessment, as such services did not result in a pay for performance bonus. Another grievance was filed by a Member that was denied an urgent care visit because the Member had not yet been seen for an initial visit, even though the Member had been assigned to the Provider for two years. The Plan, in its handling of both grievances, deemed these practices to be acceptable. The Plan did not comply with requirements that medical decisions by Providers were not unduly influenced by fiscal or administrative management considerations.

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**RECOMMENDATIONS:**

- 6.2.1 Implement internal controls to ensure that medical decisions, including scope of practice, are not influenced by fiscal or administrative concerns.
- 6.2.2 Ensure that fiscal or administrative management considerations do not result in barriers to medical care.

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6.4

### PROVIDER TRAINING

#### **Medi-Cal Managed Care Provider Training:**

Contractor shall ensure that all Primary Care Providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Contractor shall conduct training for all providers no later than 10 (ten) working days after the Contractor places a newly contracted provider on active status and shall complete the training within 30 calendar days of placing on active status....  
COHS Contract A.7.5

### **SUMMARY OF FINDINGS:**

#### **6.4.1 The Plan did not ensure completion of Provider Training**

The Plan is required to “conduct training for all providers no later than 10 working days after the Contractor places a newly contracted provider on active status and shall complete the training within 30 calendar days of placing on active status” (*Contract, Exhibit A, Attachment 7(5)*).

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. A review of 20 providers showed that 10 of them had training materials sent to them because in-person training could not be scheduled. The Plan’s records showed that 3 of 20 providers declined or cancelled their Provider Training, but only two were sent the training materials.

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. All providers, regardless of medical specialty, must comply with the Contract, Federal and State laws and regulations and it is the Plan’s responsibility to ensure all newly contracted providers are trained on these requirements.

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. A review showed that 6 of 20 providers were never trained by the Plan because they had joined a medical group. The Plan was responsible for all new Provider Training.

#### **6.4.2 The Plan did not train new Providers within the time requirements**

The Plan is required to “conduct training for all providers no later than 10 working days after the Contractor places a newly contracted provider on active status and shall complete the training within 30 calendar days of placing on active status” (*Contract, Exhibit A, Attachment 7*).

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.

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**RECOMMENDATIONS:**

- 6.4.1 Ensure the completion of new Provider Training.
- 6.4.2 Conduct training for all newly active Providers within 10 working days and complete the training within 30 calendar days.

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6.5

### FRAUD AND ABUSE

#### Fraud and Abuse Reporting

B. Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse. These requirements shall be met through the following:

4. Fraud and Abuse Reporting

Contractor shall report 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 by subcontractors, members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within ten (10) working days of the date Contractor first becomes aware of, or is on notice of, such activity....

5. Tracking Suspended Providers

Contractor shall comply with Title 42 CFR Section 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with Physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. A list of suspended and ineligible providers is maintained in the Medi-Cal Provider Manual, which is updated monthly and available on line and in print at the DHCS Medi-Cal website ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)) and by the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (<http://oig/hhs.gov>). Contractor is deemed to have knowledge of any providers on these lists. Contractor must notify the Medi-Cal Managed Care Program/Program Integrity Unit within ten (10) State working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program.

COHS Contract E.2.27.B

#### SUMMARY OF FINDINGS:

##### 6.5.1 The Plan did not report all cases of suspected Fraud and Abuse

The Plan is required to “report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe than an incident of fraud and/or abuse has occurred” (*Exhibit E, Attachment 2 (24) (1)*).

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. The Plan did not report four suspected cases of Fraud and Abuse to DHCS during the audit period.

##### 6.5.2 The Plan did not implement its Anti-Fraud and Abuse program as described in its Compliance Plan

The Contract requires that the Plan “establish an Anti-Fraud and Abuse Program...This program will establish policies and procedures for identifying, investigating and taking appropriate action against fraud and/or abuse” (*Contract, Exhibit, E (24) (B)*).

The Plan did not implement its own internal Compliance Program. The Compliance Plan stated that the Plan “shall assist the Compliance Officer in developing initiatives to detect and prevent fraud, waste and abuse” and “shall assist the Compliance Officer to identify potential risk areas throughout HPSM and help develop and implement policies and procedures resulting from the risk assessment”. The Compliance Plan designates the Compliance Committee responsible for the execution of the Anti-Fraud and Abuse Program. 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.

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The Compliance Committee held three meetings during the audit period. During the first meeting, the committee only discussed the two cases in the Fraud and Abuse log. During the second meeting, discussion of Fraud and Abuse was postponed because time ran out. During the third meeting, the committee approved the handling of Fraud and Abuse in an ad hoc committee. The acting Compliance Officer proposed that “it would be more helpful to have this handled by an ad hoc function of this committee whereby issues would be reported at this committee and if a topic needed specific focus; this committee could assign an ad hoc committee” (*Compliance Committee Minutes 062614*).

The Compliance Committee meetings served 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. Their resolutions required the responsible employee to repeat training, instead of also examining a potential need to provide improved and more effective training or increased participation in the trainings.

### **RECOMMENDATIONS:**

- 6.5.1 Report all suspected and actual cases of fraud and abuse.
- 6.5.2 Fulfill Compliance Committee responsibilities to develop and implement proactive procedures to detect fraud and abuse.

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

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

Contract Number: 08-85220  
State Supported Services

Audit Period: August 1, 2013  
Through  
July 31, 2014

Report Issued: April 28, 2015

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## **INTRODUCTION**

This report presents the audit findings of San Mateo Health Commission dba Health Plan of San Mateo (HPSM) State Supported Services contract No. 08-85220. The State Supported Services contract covers contracted abortion services with HPSM.

The onsite audit was conducted from November 3, 2014 through November 14, 2014. The audit period is August 1, 2013 through July 31, 2014 and consisted of document review of materials supplied by the Plan and interviews conducted onsite.

An Exit Conference was held on March 4, 2015 with the Plan. The Plan was allowed 15 calendar days from the date of the exit conference to provide supplemental information addressing the draft audit report finding. After the exit conference, the Plan submitted supplemental information for consideration. The auditors evaluated the information and incorporated applicable changes to this report.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Plan of San Mateo

AUDIT PERIOD: August 1, 2013 through July 31, 2014

DATE OF AUDIT: November 3, 2014 through November 14, 2014

**STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS**

**Abortion**

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

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

**SUMMARY OF FINDINGS:**

**SSS.1 The Plan did not ensure inclusion of all Contract required State Supported Services codes for claims payment**

The Plan's claims payment system did not include all the required procedure codes for state-supported services. 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.

**RECOMMENDATIONS:**

SSS.1 Include all the required state-supported services procedure codes in payment database.



JENNIFER KENT  
DIRECTOR

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



EDMUND G. BROWN JR.  
GOVERNOR

JAN 22 2016

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

RE: Department of Health Care Services Medical Audit

Dear Mr. Johansson:

The Department of Health Care Services (DHCS) Audits and Investigations Division conducted an on-site medical audit of Health Plan of San Mateo, a Managed Care Plan (MCP), from November 3, 2014 through November 14, 2014. The audit covered the review period of August 1, 2013 through July 31, 2014.

On January 11, 2016, the MCP provided DHCS with its most recent response to its Corrective Action Plan (CAP) originally issued on July 15, 2015 regarding remaining open items. At this time, all deficiencies have been reviewed and either closed or provisionally closed.

Provisionally closed deficiencies indicate that DHCS has conditionally accepted the MCP's plan of action being proposed and/or implemented in order to bring a deficiency into compliance. For this CAP, six (6) deficiencies have been provisionally closed. DHCS will continue to monitor and/or follow up on deficiencies that have been provisionally closed.

All other items have been reviewed and found to be in compliance. The CAP is hereby closed. The enclosed report will serve as DHCS's official response to the MCP's CAP.

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

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

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Sincerely,

*Originally signed by Dana Durham*

Dana Durham, Chief  
Contract Compliance Section

Enclosure:

cc: Stephanie Issertell, Contract Manager  
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Managed Care Operations Division  
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