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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

October 11, 2016

Alejandra Clyde, Compliance Officer
Health Plan of San Joaquin
7751 S. Manthey Road
French Camp, CA 95231

RE: Department of Managed Health Care 1115 Waiver Seniors and Persons with Disabilities Survey

Dear Ms. Clyde:

The Department of Managed Health Care conducted an on-site 1115 Waiver Senior and Persons with Disabilities (SPD) Survey of Health Plan San Joaquin, a Managed Care Plan (MCP), from July 13, 2015 through July 17, 2015. The survey covered the period of July 1, 2014 through June 30, 2015.

On October 7, 2016, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on March 30, 2016.

All items have been reviewed and found to be in compliance. The CAP is hereby closed. The enclosed report will serve as DHCS' final 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, feel free to contact Michael Pank, Compliance Unit, at (916) 552-8945 or CAPMonitoring@dhcs.ca.gov.

Sincerely,

Jeanette Fong, Chief
Compliance Unit

Enclosures: Attachment A CAP Response Form

cc: Yvonne Harden, Contract Manager
Department of Health Care Services
Medi-Cal Managed Care Division
P.O. Box 997413, MS 4408
Sacramento, CA 95899-7413

ATTACHMENT A
Corrective Action Plan Response Form

Plan Name: Health Plan of San Joaquin

Review/Audit Type: DMHC SPD Survey **Review Period: July 1, 2014 through June 30, 2015**

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

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

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

CORRECTIVE ACTION PLAN FORMAT

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DMHC Comments
1. Utilization Management				
1. The Plan has not demonstrated that its nurse & physician reviewers consistently apply	Inter – Rater Reliability (IRR) Testing of HPSJ's Physicians and nurses is performed annually. The next IRR is scheduled for May 1, 2016 and all staff involved in the Utilization Management Program receive testing	1. Attachment A: Policy UM06	May 2016	**06/01/16** – The following documentation supports the MCP's efforts to correct this deficiency: -Updated P&P, "Policy UM06: Medical Review Criteria" (04/16) which states inter-rater reliability (IRR) testing is conducted at least annually to assess determinations made by UM staff to

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the criteria and guidelines for medical necessity decisions. In particular, not all UM staff completed the Plan's inter-rater reliability testing.	to ensure consistent application to the criteria used for UM decisions. All nurses in the prior authorization, concurrent review, case management and appeals unit will undergo IRR testing. All full time Medical Directors and part – time Physician Reviewers will also be responsible to comply with testing. If a Physician Reviewer is not compliant, he/she will be removed from the panel until IRR is complete. All UM Staff will be re- trained in late April in preparation for the May IRR. The expected passing grade is 90%. For those not achieving 90%, additional training will be provided and a re-audit of 10 of the employee's cases will be done within 6 months. (Policy UM 06)			evaluate the consistency in applying criteria p.3) -Per HPSJ written response, all UM staff was retrained in April for the May IRR testing. Minimum scoring requirements must be met or additional training will be required. Any physicians or nurses who score below 90% will be required to be retrained and re-tested. **08/22/16** – The following additional documentation submitted supports HPSJ's efforts to correct this deficiency: -HPSJ submitted May 2016 Nursing and MD IRR testing results which indicated all nurses and/or MDs scored over 90% (minimum scoring requirement) therefore additional corrective action (e.g.: additional training, review panel removal) will not be required. **This finding is closed.**
2. Continuity of Care				
2. The Plan does not ensure follow-up services that reflect the findings or risk factors discovered during enrollees IHAs and IHEBAs	HPSJ has sponsored ongoing education sessions for the providers and their office staff about IHA monitoring and requirements. The provider in-service training session which is completed at time of contracting and annually, includes the IHA requirements. (Slide 10 of New PCP orientation) Additional educational sessions were held March 17, 2016 in San Joaquin	1. New provider education packet 2. IHA agenda 3. IHA training slides 4. IHA Training Participation List 5. Provider	June 2016	**06/01/16** – The following documentation supports HPSJ's efforts to correct this deficiency: -A written description indicating HPSJ conducted an internal audit of 472 medical records for documentation of IHA/IHEBA and appropriate follow up. Results of the survey were to be completed by 5/15/16. Results to be reviewed and follow up recommendations made.

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	(French Camp) and March 24th, 2016 Stanislaus (Modesto) Counties. Documented attendance for the two sessions for 2016 were 32 in Modesto and 75 in French Camp for total of over 100 participants. Currently HPSJ is in the process of reviewing 472 member medical records for the documentation of the IHA, IHEBA, and appropriate follow up activities. The medical records for 472 members were requested from the PCP offices and reviewed by the HEDIS Medical Record Abstractors. The results of the survey will be complete by May 15, 2016. The results will be reviewed by an interdepartmental team who will report the results along with any recommendations to the QM / UM Committee and Commission. Appropriate individual providers will also be given feedback of results. A sample of these records are reviewed for follow up actions or identified recommendations from the results of the IHA. An annual review will be conducted by the Quality Management Team, with reporting results and recommendations to the QM / UM Committee. Facility Site Reviews continue to routinely address the IHA completion, specifically requiring the providers to	incentive brochure		**08/22/16** – The following additional documentation submitted supports HPSJ's efforts to correct this deficiency: -HPSJ submitted the 2015 IHA Medical Record Verification Report and Power Point (05/20/16) verifying whether an IHA was completed (all components and staying healthy assessment), conditions identified for follow up, whether a follow up/referral was ordered. Power Point outlined proposed actions for increasing IHA compliance includes member outreach, including implementation of text program for new members, continuing provider education and highlight and quantify provider incentive program. **This finding is closed.**

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	use the Staying Healthy Assessment (SHA) tool, as outlined by DMHC/ DHCS. This tool also includes the follow up plan to the SHA on the back of the document. Those ongoing reviews include education to the providers for use of the appropriate tool with follow up and Corrective Action Plans for those sites that are not in compliance. This process is ongoing. Provider Incentives to increase IHA compliance Provider's incentives have been included for each IHA completed for CY 2016. The target is to increase completion rates and awareness of the importance for the providers. The provider incentives are paid quarterly. The providers receive the new member list in DRE (provider portal) of members that are new to their practice and therefore eligible for an IHA. New members receive information regarding the importance of IHA in the new member packet and they also receive an automated reminder call promoting compliance with IHA. Noted in July 15, 2015 QMUM Committee as addition to program description Commission Presentation of the 3/16/2016 QM/UM Update includes IHA review update.			

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	Commission Presentation of the 2/10/2016 QM/UM Update Includes the Provider incentives for CY 2016 which includes IHA.			
3. The Plan does not provide all medically necessary covered services to enrollees until CCS eligibility is confirmed	HPSJ has introduced changes that now provide all medically necessary covered services to enrollees while awaiting eligibility confirmation from CCS. CCS eligible patients are identified by CCS edits in the system as well as by concurrent review staff and providers. Policy UM 41 "California Children Services" has been revised to state that all medically necessary covered services to enrollees are covered by HPSJ while awaiting CCS confirmation of eligibility. To prevent any delays in patient care or services, routine requests are processed timely once all the necessary clinical information for making the decision are reviewed. Language that previously stated that "The plan Medical Directors determine that any prolonged delay could impede the care to the member and HPSJ Care Manager will make the necessary arrangements, keeping the CCS Care Manager informed as to the actions taken" has been removed from the previous policy.	1. Attachment A: Policy UM 41 2. Attachment B: CCS Log 3. Attachment C: Job Aid	April 2016	**06/01/16** – The following documentation supports HPSJ's efforts to correct this deficiency: -Revised Policy UM41 – California Children Services (revised 04/2016) that ensures the provision of all medically necessary covered services until CCS eligibility is determined (page 9). All medically necessary covered services are authorized by HPSJ while awaiting CCS confirmation of coverage. HPSJ has also deleted language allowing the Medical Director discretion regarding arranging for necessary care pending a delay by CCS. -"CAP CCS OP Log 2016" which provides evidence of authorization turn-around-times ranging from 0-14 days for members with CCS eligibility pending (April 2016 data). -A Job Aid, CCS Prior Authorization Review Process which requires HPSJ authorization while awaiting CCS confirmation. The process also allows for frequent contact with the local CCS offices. **This finding is closed.**

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	A new job aide for UM staff enforces the new policy with the procedure requiring HPSJ authorization while awaiting CCS confirmation. Staff now has frequent contacts with the local CCS offices in obtaining timely decisions. A log has been implemented that provides each case's date of receipt, date of HPSJ authorization, date returned to CCS and date of CCS determination.			
3. Availability and Accessibility				
4. The Plan does not maintain a program that ensures timely access to health care for Children with Special Health Care Needs (CSHCN)	HPSJ provides primary health care to the children with special health care needs through our network of primary care providers who provide care to children, which is mostly pediatricians. Access studies for primary care is conducted using the DMHC methodology. Specialty health care is provided through network pediatric specialists and through coordination of care with California Children's Services, the Regional Center and County Behavioral Health Services as needed. HPSJ does not require prior authorization for consultation with the in- network specialists. The grievances and appeals are monitored to see if there are any access issues with specialty visits and the Quality team monitors the medical	1. UM 1- Prior Authorization timelines 2. Extract of MRR tool shows Specialty Visit referral and follow up by the PCP is audited 3. UM 41- Revised Policy for CCS 4. Member Letters to Regional center Clients	April 2016	**06/01/16** – The following documentation supports HPSJ's efforts to correct this deficiency: -Revised Policy UM41 – California Children Services (revised 04/2016) that ensures the provision of all medically necessary covered services until CCS eligibility is determined (page 9). All medically necessary covered services are authorized by HPSJ while awaiting CCS confirmation of coverage. HPSJ has also deleted language allowing the Medical Director discretion regarding arranging for necessary care pending a delay by CCS. -"Analysis of Access Results" (03/28/16) as evidence that timely access to specialist, BH, and ancillary appointments was measured in the 2015 Timely Access Survey. **06/21/16** - HPSJ submitted the following additional information:

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	records during medical record reviews to see if the pediatric primary care providers are providing timely referral to a specialist and if they are following up on the referrals. HPSJ requires prior authorization for out of network specialty referrals and the prior authorizations are completed within the regulatory requirements; 72hours for urgent and 5days for non-urgent prior authorization requests per our UM policy UM01. The Medical Management team monitors the prior authorization requests for utilization of the service and if the service is not utilized, the members are called to ask for reasons for not seeing the specialist including access issues and care is coordinated as needed. Most of the specialty care for children with special health care needs is received through the California Children's Services Program. HPSJ has developed a process that ensures the provision of medically necessary covered services to members until CCS eligibility is confirmed. Authorizations are approved within required timeframes and the policy UM 41 has been amended to reflect this change. MOU's with Stanislaus and San Joaquin CCS Agencies have			-The QM/UM meeting minutes (5/18/16) which document review of the timely access survey, including specialist results (page 12). **06/28/16** - HPSJ submitted the following written response stating, "HPSJ will send a provider communication summarizing the access survey results and reminding providers of the appointment availability requirements. HPSJ is going to conduct another timely access survey this fall. HPSJ's provider network department continues to ensure network adequacy by contracting with ample providers to service our membership. HPSJ also monitors over and under- utilization as well as grievances for patterns or issues relating to access." **07/25/16** - The following additional documentation submitted supports HPSJ's efforts to correct this deficiency: -Provider bulletin (07/15/16) reminding scheduling staff of the appointment access standards and the results of the timely access survey -Timeline for Appointment Access Survey (07/20/16) which will include PCPs, specialists, ancillary and OB/GYN. Next survey will start in September 2016 and be completed by end of November 2016. Analysis is expected to be completed by mid-February 2017, establishing acceptable thresholds and overall interpretation. Overall results will be sent to all providers in a

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	been executed. Quarterly meetings are held between HPSJ Staff and CCS staff at CCS offices to ensure coordination of care, timely approval of requests and transition of patients who are "aging out" from CCS to HPSJ and to collaborate on other issues. For HPSJ children with special health care needs that receive services through the Regional Center, HPSJ sends out letters to the members asking them to call our case management team for coordination and case management needs. HPSJ has executed an MOU with the regional center and meets periodically to ensure appropriate coordination of care for the members with special health care needs. In addition, whenever needed a specialist can be assigned as the primary care provider for a member and a standing referral can be provided to an out of network provider when an in-network provider is not available, as stated in UM Policy11, which is currently in the revision and committee approval process. There is no requirement for prior authorization for in-network specialist.			general communication and follow up letters will be sent to providers that do not meet the threshold (routine and/or urgent) resulting in corrective action. Individual provider CAPs will be followed up in 6 weeks. -Timely Access Follow Up Plan (07/20/16) HPSJ will review survey responses from each provider and determine the scores for each. At the completion of the survey analysis, a threshold for compliance score will be established. Communication will be sent to all providers, outlining overall survey results by specialty and a review of appointment access standards. Those providers that score below the threshold, will receive individualized letters from HPSJ regarding their survey results. The communication will require a corrective action plan to meet requirements and follow up with each provider will be conducted. **This finding is closed.**

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5. The Plan cannot demonstrate that it is meeting or monitoring timely access standards for specialists, ancillary providers, mental health providers, or urgent care appointments	HPSJ completed and reported the 2015 Timely Access Survey and the required documentation within the 3/31/2016 required time line. The results of the survey are scheduled to be reviewed at the next QM/UM Committee meeting. The Survey included PCPs, Specialists, Ancillary and Behavioral Health providers, as outlined in the DMHC methodology. The attached analysis outlines the specifics for that report. The survey included questions using the verbiage of authorization requirements or no authorization required by the provider IPA or group or the MCO. HPSJ does not require prior authorization of urgent or routine in network office visit for PCPs or specialist. The mention of authorization may have set the respondents on an alternate method for scheduling, therefore, since it is N/A for HPSJ, there is the belief that these specific questions have the ability to skew the results. HPSJ also does direct contracting with providers rather than an IPA model. HPSJ used the vendor, CareCall, Inc for the survey. The vendor was not be able to explain to the office staff that prior authorization is not required by HPSJ.	1. DMHC methodology 2. Each of the detail and summary files for PCP, Specialist, Ancillary, and Behavioral Health 3. Analysis of Access Results	June 2016	**06/01/16** – The following documentation supports HPSJ's efforts to correct this deficiency: -A written response which indicates that the Plan completed the 2015 Timely Access Survey which did include measurement of timely access to specialist, BH, and ancillary appointments. -"Analysis of Access Results" (03/28/16) as evidence that timely access to specialist, BH, and ancillary appointments was measured in the 2015 Timely Access Survey. **06/21/16** - The Plan submitted the following additional information: -The QM/UM meeting minutes (5/18/16) which document review of the timely access survey, including specialist results (page 12). **06/28/16** - HPSJ submitted the following written response stating, "HPSJ will send a provider communication summarizing the access survey results and reminding providers of the appointment availability requirements. HPSJ is going to conduct another timely access survey this fall. HPSJ's provider network department continues to ensure network adequacy by contracting with ample providers to service our membership. HPSJ also monitors over and underutilization as well as grievances for patterns or issues relating to access." **07/25/16** - The following additional documentation submitted supports HPSJ's

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				efforts to correct this deficiency: -Provider bulletin (07/15/16) reminding scheduling staff of the appointment access standards and the results of the timely access survey -Timeline for Appointment Access Survey (07/20/16) which will include PCPs, specialists, ancillary and OB/GYN. Next survey will start in September 2016 and be completed by end of November 2016. Analysis is expected to be completed by mid-February 2017, establishing acceptable thresholds and overall interpretation. Overall results will be sent to all providers in a general communication and follow up letters will be sent to providers that do not meet the threshold (routine and/or urgent) resulting in corrective action. Individual provider CAPs will be followed up in 6 weeks. -Timely Access Follow Up Plan (07/20/16) HPSJ will review survey responses from each provider and determine the scores for each. At the completion of the survey analysis, a threshold for compliance score will be established. Communication will be sent to all providers, outlining overall survey results by specialty and a review of appointment access standards. Those providers that score below the threshold, will receive individualized letters from HPSJ regarding their survey results. The communication will require a corrective action plan to meet requirements and follow up with each provider will be conducted.

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				This finding is closed.
6. The Plan does not monitor compliance with the required timeframe of enrollees first pre-natal visits	HPSJ monitors the compliance with the required timeframe of enrollee's first pre-natal visit through the following methods: HPSJ initiated a modified Access survey using the DMHC methodology for OB visits, both urgent (within 48 hours) and routine within two weeks. This survey was conducted the first 2 weeks of April, 2016. **Survey Results:** Routine Office visits within 2 weeks = 100% compliant Limitations of survey: • Denominator of those Offices that were willing to answer the survey was low. About half of the offices' scheduling staff or administrative personnel refused to answer the Access survey. This is obviously a source of irritation with the office staff by comments that were received at the time of survey. However, those that	1. DMHC methodology 2. Spreadsheet 3. Script	April 2016	**06/01/16** – The following documentation supports the MCP's efforts to correct this deficiency: -In a written response, HPSJ indicated that it conducted a survey in April 2016 to measure timely access to prenatal appointments. Survey results indicated 100% compliance. -HPSJ also analyzed grievances related to OB access. -HPSJ also submitted the revised DMHC Provider Appointment Availability Survey which incorporates measurement of timely access to prenatal appointments. - QM/UM Committee meeting minutes which document discussion of HPSJ's Access Survey results including timeliness with OB appointments (page 12). **This finding is closed.**

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	participated were very helpful. • Many of the OB specialists listed for the sample are no longer taking primary responsibility of routine patients for delivery, however have oversight responsibilities for office visits or office administrative functions. Therefore, the office staff did not answer the survey for that practitioners. • Total denominator for those completing survey was 32 out of the sample of 53. **Additional supporting information:** **DMHC Grievance Access Report – 2015** This report was submitted to DMHC 4/15/2016 for Calendar Year 2015. Analysis of the 234 access issues showed only 12 (5.1%) were related to OB practices in any way. The breakdown of the grievances is the following: • 2 issues with insurance verification or EMR systems in the provider			

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	office
	• 1 OB referral of patient to high risk OB due to comorbid conditions
	• 4 Appointment timeliness for routine visit
	  ○ 1 in 13 days
	  ○ 1 in 3 days
	  ○ 1 in 4 days and
	  ○ 1 post-visit in 10 days (grievance after appointment
	• 2 Requested non contracted facility as personal preference
	• 1 Request to change OB provider
	• 2 Referrals from OB provider for patient PCP (no PCP)
	(Please note that in all cases the appointment was within the required timeframe of 14 days for a routine			

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	visit) **HPSJ Access Performance Standards** The 2015 Access standards for the DHCS standards for OB/GYN Access demonstrated the following achievement goals met: **Summary:** All aspects of HPSJ's current measurement systems has demonstrated that it meets the contractual requirement for initial prenatal appointments within two (2) weeks. Review of the Survey, the DMHC 2015 Grievance Access report, and the Access Performance Standards report all confirm that HPSJ meets the requirement.			

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7. The Plan has not established standards for geographic distribution of hospitals, emergency services facilities, or ancillary facilities	Updated PRO08 Policy and Procedure to include the following: State regulations and HPSJ requires that specialists, ancillary, in-patient, emergency and urgent care facilities and providers are available and accessible within each service area. At a minimum, designated emergency service facilities, providing care on a 24-hour, 7-day per week basis is required. These designated facilities will have one or more physicians and at least one nurse on duty in the facility at all times. HPSJ makes every effort to contract with specialists, ancillary, in-patient, emergency and urgent care facilities and providers located within 15 miles and 30 minutes. Exceptions may be lack of certain specialties or rural areas where there are limited services. HPSJ will make special arrangements for specialty services not available within the service areas on a case-by-case basis.	1. PRO08 Maintaining Member to Provider Ratio 2. CONT02 Provider Contracting-Credential	April 2016	**06/01/16** – The following documentation supports HPSJ's efforts to correct this deficiency: -Updated P&P PRO08 Monitoring Provider to Member Ratio (04/16) which outlines geographic standards for specialists, ancillary care facilities and emergency services facilities located within 15 miles and 30 minutes, exceptions may include lack of certain specialties or rural areas where there are limited services (page 2). Side Note: On Policy PRO08, under I. it states PCPs should be located within 15 miles and 30 minutes from the member's residence. This should be revised to reflect the correct distance of 10 miles for PCPs as per the Medi-Cal contract (Ex. A, Attachment 6, Provision 8). **08/25/16** – Updated P&P, PRO08 Monitoring Provider to Member Ratio (04/21/16) which has been amended to include the correct time and distance standard for PCPs. This P&P was also approved by DMHC on 7/7/16. **This finding is closed.**

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4. Member Rights				
8. The Plan did not consistently acknowledge enrollee grievances and appeals in writing within five calendar days of receipt	Health Plan of San Joaquin's grievance department receives, reviews, and categorizes all member grievances. In July 2015 after receiving recommendations following the DHCS audit the Quality Management revised, and updated its grievance policies, and procedures. This included providing separation of Clinical vs. Non Clinical grievances. All Clinical grievances are investigated by the Quality Management Nurse, and forwarded to the Medical Director for review and final determination. The Medical Director scores, and levels each clinical case using the updates scoring methodology. Non Clinical Grievances can be investigated scored, and closed by either a Grievance Coordinator or the Quality Management Nurse who may level and score the case. All cases with any known aspect or questions regarding quality of care are included in the clinical track. The Grievance Staff has continued to receive training to ensure that all aspects of an enrollee grievance are investigated and addressed. All case designations are now assigned after a thorough investigation has occurred rather than assigning the case designation at the beginning of the case. This allows	1. GRV 02 Member Grievance Process 2. GRV04 Grievance Committee 3. Sample Audit Tool 4. Grievance Process Update – Power Point Presentation	April 2016	**06/01/16** – The following documentation supports the MCP's efforts to correct this deficiency: -Power Point training, Quality Management Call Log Process which references the five calendar day requirement under key timeframes (page 8). -Updated P&P, GRV02 "Member Grievance Procedures" to reflect requirement of five calendar days to mail grievance acknowledgement letters. **09/22/16** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: -Grievance Process Audit Tool also includes a field to measure timely acknowledgement. Quarterly audits are conducted on 10% of all grievances to ensure timely acknowledgement letters are sent out within 5 calendar days. -Written description indicating grievance department holds weekly meetings. Each week grievance cases from the previous week are reviewed to ensure timely acknowledgement. This allows for an extra level of monitoring. -Grievance Committee meets on a monthly basis to review case turnaround times and to ensure compliance rate of both the acknowledgement and resolution of grievances and appeals is above 95%.

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	that case are being investigated and closed appropriately. Following the above steps helps to ensure that enrollee grievances are given every consideration to bring about the most appropriate resolution, and ensure that all grievances regarding quality of care issues are reviewed by the medical director. Currently the grievance case audit includes an audit of appropriate referrals of all clinical and quality of care issues to the Medical Director. In preparation for HPSJ grievance committee, monthly, and quarterly reporting grievances cases are reviewed to ensure appropriate designation, timely acknowledgment, appropriate medical director referral and resolution. The Quality Management Department has also developed and implemented a point system to score grievances. This allows for a better method of tracking, trending, and developing interventions for provider grievances. This allows for better monitoring of providers between recredentialing cycles. Revisions were made to GRV02 the HPSJ grievance policy to capture these changes. HPSJ has implemented multiple steps to ensure enrollee grievances are given adequate consideration, and any			**10/7/16** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: -Weekly Tag-Up meeting agenda (10/6/16) indicating that timely acknowledgement and resolution was to be discussed. -Completed sample audit tool and results (7/26/16) which includes timely acknowledgement. Overall results fell below 95% target (91.43 overall compliance). Areas of non-compliance did not have to do with timely acknowledgement. **This finding is closed.**

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	grievance regarding quality of care is reviewed by the Medical director.			
9. The Plan does not consistently ensure adequate consideration of standard enrollee grievances	Based on feedback received during the 2015 DHCS audit the Grievance department implemented procedures to adequately aggregate and analyze 24 hour or exempt grievances. On a monthly basis the HPSJ grievance committee meets to discuss all grievances categories including those that are closed as exempt or within 24 hours. While these grievances are included in the overall total number, they are looked at separately as well. On a daily basis the HPSJ Grievance team reviews daily call log sheets from the Customer Service department to ensure that no grievance has been closed as exempt. This case designation is only applied after a case is reviewed and determined to not contain any quality of care component. Please see the chart review from the Health Plan of San Joaquin January 2016 Grievance Committee. Reflected in the chart are Exempt Grievances which are grievances resolved within hours. Below the chart is a summary of the grievance totals.	1. GRV02 2. GRV04 3. Grievance Process PowerPoint	April 2016	**06/01/16** – The following documentation supports the MCP's efforts to correct this deficiency: -Power Point training, Quality Management Call Log Process which addresses adequate investigation and resolution of grievances. Audits will be conducted to measure this component. **10/7/16** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: -Revised grievance audit tool that includes additional elements to ensure all issues raised in the grievance is categorized for tracking and trending purposes, all issues are identified correctly, and whether the MCP considered and rectified all issues raised. **This finding is closed.**

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	Total number of grievances= 41 15 Quality of Care concerns, 14 Access to Care issues, 11 Attitude and Service issues, • 6 grievances were processed as "Exempt grievances" The Health Plan of San Joaquin Grievance process training was also updated to include the explanation and of exempt grievances. This PowerPoint training is used to provide education on the grievance process to several departments within the HPSJ. There were also updates made to grievance policies to accurately reflect the handling of exempt grievance.			
10. The Plan does not appropriately categorize exempt grievances	Grievances received by telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day are exempt from the requirements to send a written acknowledgement and response, and will be logged as such in the Member Grievance Log. Exempt grievances are resolved the same as standard grievance, with the exception of the acknowledgment and resolution letter.	1. GRV02 2. GRV04 3. Grievance Process PowerPoint 4. Customer Service Training	April 2016	**06/01/16** – The following documentation supports HPSJ's efforts to correct this deficiency: -Power Point training, Quality Management Call Log Process which addresses exempt grievances (slides 4 and 5). -A written response indicating that on a monthly basis, the grievance committee meets to discuss all grievance categories including exempt grievances. The response included documentation of 41 exempt grievances broken down by category/outcome. -Policy GRV04 – Grievance Committee

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	The Health Plan of San Joaquin Grievances department has developed the steps necessary to ensure that any grievance resolved as an Exempt Grievances do not contain issues regarding enrollee complaints of any type of services that includes the quality of care in which they received or are attempting to access. Based on feedback received during the Department of Managed Health Care Audit in July 2015 the Grievance department took steps to ensure that the Customer Service Department was educated to not close any issues received as Exempt grievances. This case designation could only be assigned by the Grievance Team. Education of both the Customer Service and Grievance departments included the following components. 1. Definition of Exempt Grievance 2. Definition of a Standard Grievance 3. Examples of grievance types. The Grievance Departments monitors all cases designated with a grievance code by the customer services team daily to ensure that there are no			(01/2015) which indicates that exempt grievances are presented at the Grievance Committee to ensure correct processing and closure (page 1). -Quarterly Grievance Committee meeting minutes and reports (February 26, 2016; March 22, 2016) that indicates grievances are addressed by category. **This finding is closed.**

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	cases that have been designated as Exempt. Training of the Grievance staff included emphasis on any case with quality of care concern may not be handled as exempt. This includes, but is limited to PCP change, and lack of appointments. The Quality Management Department has developed new processes to include all issue related to clinical issues being reviewed by a Medical Director. This process helps to ensure that any case with a clinical component are not closed as exempt. The HPSJ grievance committee meets on a monthly basis to review all grievance categories including those that have been resolved and closed as exempt. As reports are prepared for this meeting this helps to ensure that any case closed as Exempt did not included any Quality of Care component.			
5. Quality Management				
11. The Plan's Quality Assurance Program does not document the quality of care provided is being reviewed, that problems are being identified,	Quality Follow up: The HPSJ Quality Work plan is designed for follow up reporting on a quarterly basis, at a minimum. These updates are given for Quality and UM topics. (See QM Work Plan Initial 2016 attached) The minutes also demonstrate ongoing monitoring of the Work Plan. (Approved Min QMUM: 091615 and 071515)	1. Delegation Oversight Spreadsheet 2. DOC Minutes Bookmark from Sept. 4, 2015, 3. Commission	July 2015	**06/01/16** – The following documentation supports HPSJ's efforts to correct this deficiency: -Delegation Oversight Committee meeting minutes which provide evidence of documented review and discussion of delegated entity, Beacon and their CAP for not meeting call standards, quality information, delegation oversight of UM, QM and member rights and responsibilities, and CAP requirements for

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that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated	Delegation oversight HPSJ has a process in place for continuous monitoring and oversight of delegated entities through the timely receipt and review of the oversight reports. The pre-delegation documents and review were completed prior to delegation. This is noted in the attached CHIPPA Beacon Health Delegation Approval Letter from the Director of Quality. HPSJ has also attached the 2014 QMI Program Description for Beacon. Documentation of Oversight Review and findings are found on secured spreadsheets. (Master Copy FY 2015 Delegated Oversight Reporting_12_24_2015) Oversight reports were made at the Delegation Oversight Committee. The Delegation Oversight Committee reported through the QOC until August 2015. At that time the reporting function was changed to QMUM Committee. On September 4, 2015, several of the Health Plan Executives, including the CEO and CMO, Chair of QMUM, met to further define, revise, but more importantly outline the oversight focus. The focused actions and follow up from this group initiated more support for the ongoing follow up to any reports including those that were not delivered timely or that did not meet the threshold from the contractual	minutes including DOC reports. 4. HPSJ/Quest Meeting summary 5. 2016 Quest Deliverables Status 6. QA 27 policy: Potential Quality Issue Report 7. QOC meeting minutes w Quest encounter information 8. Approve Min QMUM 091615 and 071515 9. GRV02 Grievance final (Policy) 10. Managed Behavioral Health Admin		delegated entities (1/11/16, 8/19/15, 10/26/15). -QM/UM Committee Update meeting minutes which provide evidence of documented review and discussion of delegation oversight quarterly reports of Beacon, Kaiser and VSP, increased focus on clinical quality improvement (3/16/16, 7/15/15, 9/16/15). -Updated P&P, QA27 Potential Quality Issue (PQI) Report (04/16) which provides a systematic method for identification, reporting and processing of potential quality issues to determine opportunities for improvement. Report triggers for potential quality issues can come from a variety of areas (page 3) and require corrective action. -QM Work Plan which outlines planned activities to track/trend PQI on a quarterly basis, identify consistent patterns of PQI, and development interventions to address quality issues. -Behavioral Health Administrative Services Agreement as evidence that HPSJ engage in oversight activities and perform reviews to ensure delegated entities are properly performing all required functions (page 8 – General Provisions). **This finding is closed.**

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	agreement. Follow up has consistently been that the business owner at HPSJ reviews the ongoing oversight reports received and reports findings to the Delegation Oversight Committee. These are also shared at the QMUM report and also for the Board of Commissioner's Meetings. Evidence of the importance of these oversight is noted not only in minutes but also the Notice of Non-Compliance which is issued to a delegated provided in the event non-compliance with contractual or regulatory requirements is identified. The primary reason for the Notice is non-compliance is document that the delegated entity has been made of aware of the issue, and inform the delegated entity to correct the issue within the timeframe mandated by HPSJ. (See DOC 10_26_2015) The actions and follow up demonstrated give support and credibility to the fact that receipt of these reports are not only important, but that the report meets previously set thresholds. The Subject Matter Expert at HPSJ maintains the responsibility for review of the delivery process and outcomes measured for the oversight of care provided. (DOC 8_19_2015, DOC 1_11_15) The Delegation Oversight Committee	Service Agreement 11. Quest Meeting summary		

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	reports are included in the CMO report to the SJ Health Plan Commission, quarterly. (Examples of presentations attached) HPSJ plan is to continue the specific and targeted actions noted, as well as reporting at the Delegation Oversight Committee, quarterly reporting to the QMUM and Commissioners Meetings. <u>PQI identification and review for action</u> HPSJ continues to strengthen the system for identification of PQI issues and ensuring clinical review. PQIs may be identified at several time frames throughout the process: 1. Those that are initially triaged as PQIs are identified as such and forwarded to the QM department for review by a Quality Nurse for investigation. This is most frequently from Care Management or Utilization Review staff. The multidisciplinary team is encouraged to send any issue that may seem to be PQI to the QM department. Examples of those issues include readmissions for the same diagnosis within 30 days, post-operative infections, and other member			

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	outcomes that may have a quality issue. 2. The routine grievance may be escalated to a PQI by the Quality Nurse, Supervisor or Medical Director during the investigation. At this time, all grievances are triaged by a clinical QI Nurse. (Policy GRV02 Grievance final) This will facilitate including any of the clinical grievances that may need to be categorized as a PQI initially or after investigation. 3. The Medical Director also reviews all clinical grievances and may escalate to a PQIs at time of review. All documentation has started to be included in one software program, Everest. This includes the Grievance Coordinator, Quality Nurse and Medical Director, as well as clinical review notes, etc. All PQIs are reviewed by the medical director or physician designee. They determine the level of the PQI and make recommendations for action which may include referral to Peer Review Committee or provision of corrective action plans. HPSJ believes this will			

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	lead to more efficiency and compliance with identification and follow up for PQI issues. This process will continue ongoing. Behavioral Health Delegation The initial contract with Beacon described the activities, roles and responsibilities includes Attachment C-1 with the Quality deliverables specified. (Managed Behavioral Health Admin Service Agreement attached) Ongoing review of the activities and oversight are well outlined and the responsibilities and follow up are documented in several of the attachments: (Delegation oversight spreadsheet, Delegation oversight Committee minutes, and HPSJ Health Commission presentations given by the CMO.) Ongoing monitoring is noted in the spreadsheet for delegation oversight reporting. The reports are now given to the appropriate HPSJ Department subject matter expert (SME) and reported by the SME at the Delegation Oversight Committee. (See minutes attached) Beacon was actually issued a Corrective Action Notice of Non-Compliance January 2016. This also demonstrates the plan's follow up and focus on these delegated actions. HPSJ plans to continue the ongoing monitoring and oversight through the			

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	reports to the Delegation Oversight Committee, QMUM committee and direction of the HPSJ Commission. Follow up will continue for the Corrective Action Plan, as indicated. Lab and Outpatient surgery centers The primary Lab contract with HPSJ is with Quest. Ongoing monitoring for the encounter data by HPSJ has been followed with additional analysis by the IT business analyst group and discussed in the QOC meeting recently (3/28/16). An additional listing of specific ongoing lab topics with Quest is attached. The most recent significant topic continues from 2015 discussions for BRCA testing. In addition, the Quest Deliverables Status overview is attached, noting completed and ongoing projects. HPSJ will continue the have ongoing dialogue and interface with Quest for follow up on current issues and additional issues as they arise to the surface. The mechanism noted for identification of outpatient surgical services would continue to be the PQI. There were no PQIs in the sample of 30 that were pulled at the time of the audit, however, this is the mechanism used by Case Management and Utilization Management staff to communicate unplanned admissions following			

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	outpatient surgery and surgical infections, for example. These are not frequent incidents overall, however, this is the mechanism for reporting, with follow up clinical review with the QM Nurse, Medical Director and Peer Review/Credentialing committee if needed. (Policy QA 27 for Potential Quality Issue Reporting)			

Submitted by: _____ **Date:** _____

Title: _____