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

REPORT ON THE MEDICAL AUDIT OF

# San Mateo Health Commission
# dba Health Plan of San Mateo

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| Contract Number: | 08-85213 |
| Audit Period: | November 1, 2016<br>Through<br>October 31, 2017 |
| Report Issued: | May 24, 2018 |

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# I. INTRODUCTION

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

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

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

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

As of October 31, 2017, Health Plan of San Mateo's total membership was approximately 146,927. Membership composition was 112,193 for Medi-Cal (76.36%), 21,535 for ACE Program (14.65%), 9,261 for Cal MediConnect (6.30%), 1,605 for California Children's Services (1.10%), 1,277 for Healthy Kids (.90%), and 1,056 for HealthWorx (.72%).

# II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of November 1, 2016 through October 31, 2017. The onsite review was conducted from November 27, 2017 through December 8, 2017. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on May 1, 2018 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 findings. The Plan submitted a response after the exit conference. The results of our evaluation of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Member Rights, Quality Management (QI) and Administrative and Organizational Capacity.

The prior DHCS medical audit for the period of November 1, 2015 through October 31, 2016 with onsite review conducted from November 28, 2016 through December 2, 2016 was issued on March 2, 2017. This audit examined the Plan's compliance with its DHCS contract, and assessed implementation of its prior year's corrective action plan (CAP).

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category follows:

**Category 1 – Utilization Management**

The audit revealed deficiencies in the Plan's UM program. The Plan is required to develop, implement and continuously update the UM program for covered services. The Plan did not continuously update or evaluate its UM program during the audit period.

The Plan is required to ensure that its pre-authorization, concurrent review and retrospective review procedures meet specific minimum requirements. A retrospective review is a review to determine if a treatment or service that was already provided was medically necessary. The Plan recently changed its process for retrospective reviews to no longer retroactively review or pay claims submitted for unauthorized services and did not have written procedures in place to process retrospective reviews. The Plan denied retrospective reviews without a review by a qualified physician.

The Plan did not have a referral tracking system to track prior authorizations to completion on an ongoing basis or a system to monitor that members received requested medical services to completion.

The Plan is required to maintain a system to ensure accountability for delegated quality improvement activities. The Plan did not conduct any annual oversight of utilization management functions performed by its delegated entity. The Plan did not evaluate a subcontractor's ability to perform the required services prior to the start of the delegation agreement.

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

Category 3 covers members' access to medical appointments and medication.

The Plan did not ensure that a policy and procedure was in place at contracted emergency departments to ensure that a 72-hour supply of medication is available to members in emergency situations.

**Category 4 – Member Rights**

Category 4 includes requirements for the appropriate handling of grievances and protected health information (PHI). The Plan is required to submit an update to DHCS within 72 hours of discovery of any security incident, breach, or unauthorized use or disclosure of PHI or confidential data. The Plan did not submit an updated "DHCS Privacy Incident Report" within 72 hours of discovery of a breach or security incident.

The contract requires that a medical director resolve grievances related to medical quality of care. The Plan's medical director did not review quality of care grievances before the resolution letters were sent.

**Category 6 – Administrative and Organizational Capacity**

The contract requires that all cases of suspected fraud or abuse by subcontractors, members, providers or employees are reported to DHCS. The results of any preliminary investigation shall be reported to DHCS within 10 working days of the date the Plan first becomes aware of such activity. The Plan did not report cases of suspected fraud or abuse to the Department of Health Care Services within 10 working days.

# 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 including seniors and persons with disabilities (SPD) comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

## PROCEDURE

The onsite review was conducted from November 27, 2017 through December 8, 2017. 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: 7 medical and 7 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal procedures: 7 prior authorization appeals were reviewed for appropriate and timely adjudication.

### Category 3 – Access and Availability of Care

Appointment availability verification study: 20 providers' offices from the Plan's in-network providers of routine, urgent, specialty, and prenatal care were surveyed.

### Category 4 – Member Rights

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

Confidentiality rights: 10 Health Insurance Portability and Accountability Act (HIPAA)/protected health information (PHI) breach and security incidents were reviewed for appropriate reporting and processing.

**Category 5 – Quality Management**

Potential quality of care issues: There were 5 samples reviewed for appropriate reporting and proper treatment.

**Category 6 – Administrative and Organizational Capacity**

Fraud and abuse: 10 fraud and abuse cases during the audit period were reviewed for appropriate reporting and processing.

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

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

**AUDIT PERIOD:** November 1, 2016 through October 31, 2017
**DATE OF AUDIT:** November 27, 2017 through December 8, 2017

## CATEGORY 1 - UTILIZATION MANAGEMENT

| 1.1 | UTILIZATION MANAGEMENT PROGRAM |
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**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

**Review of Utilization Data:**
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 FINDING(S):**

### 1.1.1 Utilization management (UM) program evaluation

The Plan is required to 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. *(Contract A18, Exhibit A, Attachment 5 (1))*

The Plan's UM program stated, "The Utilization Program is reviewed and evaluated for effectiveness at least annually by the Medical Director and the Director of Health and Provider Services. Recommendations for revisions and improvement are made as appropriate and the subsequent annual Utilization Program is based on the findings of the annual program evaluation."

The Plan did not demonstrate that it continuously updated and improved its UM program.

The Plan submitted a section of its provider manual titled Section 7 Utilization Management as its UM program. This document was not signed nor dated. Furthermore, this document was not reviewed and approved by any committee such as quality improvement (QI) or the Board. When asked during the interviews about an evaluation of its previous UM program, Plan staff stated that this was integrated in its QI evaluation. However, upon review of the QI evaluation there was no mention of the UM program and how it performed the previous year. Additionally, there was no mention of a UM evaluation and a plan for changes to improve in any of the meeting minutes including UM, QI and the Board.

If a Plan does not evaluate the performance of its UM program, it will be unaware of necessary changes to improve performance and deliver better care to members.

**RECOMMENDATION(S):**

1.1.1 Implement a process to continuously update and improve the UM program.

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| 1.2 | PRIOR AUTHORIZATION REVIEW REQUIREMENTS |
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**Prior Authorization and Review Procedures:**
Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements… (as required by Contract)
COHS Contract A.5.2.A, B, C, F, H, I

**Exceptions to Prior Authorization:**
Prior Authorization requirements are not applied to Emergency Services, Minor Consent Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.
COHS Contract A.5.2.G

**Timeframes for Medical Authorization**
Pharmaceuticals: 24 hours or one (1) business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1).
COHS Contract A.5.F

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

**Denial, Deferral, or Modification of Prior Authorization Requests:**
Contractor shall notify Members of a decision to deny, defer, or modify requests for Prior Authorization by providing written notification to Members and/or their authorized representative…This notification must be provided as specified in Title 22 CCR Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01.
COHS Contract A.13.8.A

**SUMMARY OF FINDING(S):**

### 1.2.1 Retrospective review requirements

The Plan is required to ensure that its pre-authorization, concurrent review and retrospective review procedures meet specific minimum requirements, which include that qualified health care professionals supervise review decisions, including service reductions, that a qualified physician will review all denials that are made on the basis of medical necessity, and that a determination of retrospective reviews will be made within 30 calendar days in accordance with Health and Safety Code Section 1367.01(h)(1). *(Contract A18, Exhibit A, Attachment 10 (1); Attachment 5 (2)(3)(E); Attachment 5 (2)(A))*

Plan *Policy # UM-02: Pre-Service and Concurrent Determination Timeframes for Medi-Cal* dated 3/22/2016 outlined processing timeframe compliance for pre-service medical authorizations and concurrent authorizations, but it did not include procedures for retrospective reviews.

The Plan changed its process for retrospective reviews in September 2016, deciding that it would no longer retroactively review or pay claims submitted for unauthorized services. According to interviews of Plan staff, the Chief Medical Officer together with the Director of Health Services Operations made this decision based on other health plans' common practices. In the fall of 2016, the Plan sent all providers a newsletter that stated in part: "No More Retrospective Authorization Requests - As of September 1, 2016, HPSM no longer retroactively reviews or pays claims submitted for unauthorized services. Exceptions to this rule will be made for certain rare cases, such as emergency and urgent out-of-area services, but providers must get preauthorization for all service in order to receive payment."

A review of two retrospective reviews was conducted. In one case the member was admitted (electively for a laminectomy) but while recovering the member complained of abdominal pain and general surgery was consulted. A cat scan of the abdomen showed a swirl sign concerning for small bowel volvulus (when a loop of intestine twists around itself). An evaluation indicated that he needed a diagnostic laparoscopy and possible small bowel resection. The discharge summary indicated the patient had an exploratory laparoscopy, exploratory laparotomy, appendectomy and small bowel resection.

The second case involved a member with a malignant neoplasm (cancer) of connective and soft tissue who received an injection of Olaratumab, which is a medication used to treat soft tissue sarcomas (cancer). The request form indicated retrospective and urgent.

Both retrospective reviews were denied on the basis of prior authorizations not being submitted prior to delivering services. The Plan's process did not evaluate for medical necessity for meeting an exception, or elevated to a physician for review even though the requests indicated the urgency of the treatments. These were considered administrative denials. An administrative denial is a denial of services that is based on reasons other than the lack of medical necessity. For both cases, there was no review of medical necessity done by a physician. In addition, both cases were not resolved within the contract requirement of 30 calendar days.

If the Plan does not review retrospective requests this may lead to a denial of covered benefits without a medical necessity review by a physician as well as inappropriate denial of payment to providers.

### 1.2.2 Procedures for processing retrospective reviews

The Plan is required to submit a written description of UM program that describes appropriate processes to be used to review and approve the provision of medical services to include: procedures for pre- authorization, concurrent review, and retrospective review. *(Contract A18, Exhibit A, Attachment 18 (5)(A)(1))*

Plan *Policy # UM-02: Pre-Service and Concurrent Determination Timeframes for Medi-Cal* dated 3/22/2016 outlined processing timeframe compliance for pre-service medical authorizations and concurrent authorizations, but it did not include procedures for the retrospective review process.

The Plan's provider manual and UM program stated the following: "An authorization must be obtained from HPSM prior to rendering the requested service to ensure reimbursement (see 'Retro authorization policy' section)." However, there was no "retro authorization policy" section in the Plan's UM program or provider manual.

The Plan did not have written procedures on how to process retrospective reviews. In September 2016, the Plan decided that it would no longer retroactively review or pay claims submitted for unauthorized services, however the Plan did not update its current policy to include the procedures for retrospective reviews. The Plan's original policy and provider manual did not address retrospective reviews. During interviews, Plan staff stated that they issued an article in their fall provider newsletter, and also posted a notice on their provider portal.

If appropriate procedures on how to process a retrospective review are not clearly documented, Plan staff may inappropriately handle a review and a provider may not be aware of the restrictions which can both lead to denial of covered benefits as well as providers not receiving payments.

**RECOMMENDATION(S):**

**1.2.1** Develop processes that include the review of retrospective requests and ensure that a physician performs reviews for medical necessity.

**1.2.2** Develop and implement a written description of UM program that describes how to process retrospective reviews.

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| 1.3 | REFERRAL TRACKING SYSTEM |
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| **Referral Tracking System:**<br>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.<br>COHS Contract A.5.1.F | |

**SUMMARY OF FINDING(S):**

### 1.3.1 Referral tracking system to monitor prior authorizations

The Plan is required to ensure that the UM program includes an established system to track and monitor services requiring prior authorization. The system shall include authorized, denied, deferred, or modified prior authorizations, and the timeliness of the determination*. (Contract A18, Exhibit A, Attachment 5 (1)(F))*

Plan *Policy # UM-02: Pre-Service and Concurrent Determination Timeframes for Medi-Cal* dated 3/22/2016 outlined processing timeframe compliance for pre-service medical authorizations and concurrent authorizations, but it did not include a process for referral tracking of prior authorizations to completion.

The Plan did not track and monitor services requiring prior authorization to completion. When asked during the interviews, Plan staff confirmed that they do track timeliness of prior authorization determinations but they do not track whether approved services were received by the member.

If prior authorizations are not tracked to completion, members may not receive services and the Plan may not be aware of whether a member received needed services. This information is critical to ensure that members receive care and to prevent adverse health outcomes.

**RECOMMENDATION(S):**

**1.3.1** Develop and implement policies and procedures to ensure that services requiring prior authorization are tracked and monitored to completion.

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| 1.4 | PRIOR AUTHORIZATION APPEAL PROCESS |
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| **Appeal Procedures:**<br>There shall be a well-publicized appeals procedure for both providers and Members.<br>COHS Contract A.5.2.E | |

**SUMMARY OF FINDING(S):**

### 1.4.1 Written consent from the member for appeals filed by a provider

The Plan is required to implement and maintain a Plan level appeal process to resolve member appeals. Member, or a provider acting on behalf of a member and with the member's written consent, may file an appeal. If State law permits and with the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, on behalf of an enrollee*. (Contract A18, Exhibit A, Attachment 14 (5)(A)), (Title 42, CFR, Sections 438.402(c)(1)(ii))*

The All Plan Letter *(APL) 17-006* titled, *Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments* dated May 9, 2017 states, "Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary. MCPs shall continue to comply with this existing requirement in accordance with the DHCS Contract and federal regulations."

Plan *Policy# GA-08*: *Member Appeal Procedure for Non-Medicare Lines of Business* stated, "Appointment of Representative: If the person requesting the appeal claims to be an authorized or appointed representative of the member but no documentation is on file to prove representation, the G&A Coordinator contacts both the member and his/her purported representative to obtain confirmation of this relationship." The policy does not mention the specific requirement to obtain written consent when the person filing is the provider.

The Plan did not have a procedure to obtain written consent from a member when a provider files an appeal on members' behalf.

During interviews, Plan staff confirmed that when a provider files an appeal on the member's behalf they currently do not require a verbal or written consent, it is simply accepted. Written consent is a contract requirement and also reiterated in the new APL-17-006. Plan staff stated they are working on a process to incorporate this existing requirement without causing delay in resolving appeals.

Not obtaining written consent from a member when a provider files an appeal on their behalf may interfere with patient autonomy, which is the right of patients to make decisions about their medical care without their health care provider's influence.

### 1.4.2 Evidence of coverage (EOC)

There shall be a well-publicized appeals procedure for both providers and members. The Plan is required to provide all new members with written member information including the requirements for timeframes to filing a grievance or appeal. *(Contract A18, Exhibit A, Attachment 5, (2)(E)*

The All Plan Letter *(APL) 17-006* titled, *Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments* dated May 9, 2017 states, "New federal regulations require beneficiaries to file an appeal within 60 calendar days from the date of the notice of action (NOA). MCPs shall adopt the 60- calendar day timeframe in accordance with the new federal regulations."

The Plan did not update its member EOC to include the new timeframes for filing appeals that became effective July 1, 2017.

During the onsite audit, the Plan confirmed that the EOC had not been updated. The Plan submitted a written statement that upon review, the Final Rule updates were incorporated into the EOC and approved by DHCS in August 2017 but its marketing department did not update the EOC on the website or in print. The Plan developed corrective action plans while onsite, and submitted the updated EOC but the dates for filing appeals were still incorrect. The timeframes for filing an appeal still stated 90 days instead of the required 60 calendar days.

If member written information is not updated with current information, such as with new timeframes on when to file appeals, members may be inappropriately denied services that they rightfully deserve.

**RECOMMENDATION(S):**

**1.4.1** Revise and implement policy and procedures to ensure that written consent is obtained when a provider files an appeal on the member's behalf.

**1.4.2** Develop and implement policy and procedures to ensure that correct timeframes for filing an appeal are reflected in the EOC.

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| 1.5 | DELEGATION OF UTILIZATION MANAGEMENT |
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| **Delegated Utilization Management (UM) Activities:**<br>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.<br>COHS Contract A.5.5 | |

**SUMMARY OF FINDING(S):**

### 1.5.1 Monitoring of delegated utilization management (UM) functions

The Plan is required to maintain a system to ensure accountability for delegated quality improvement activities that at a minimum ensures subcontractor meets standards set forth by the Plan and DHCS, and includes the continuous monitoring, evaluation and approval of the delegated functions. *(Contract A18, Exhibit A, Attachment 4, 6(B))*

The Plan's governing body and any internal or contracting providers to whom quality assurance (QA) responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective quality assurance (QA) program responsibilities. Any delegated entity must maintain records of its QA activities and actions, and report to the Plan on an appropriate basis and to the Plan's governing body on a regularly scheduled basis, at least quarterly, which reports shall include findings and actions taken as a result of the QA program. *(CCR, Title 28, Section 1300.70(2)(C))*

Plan *Policy # HS-05: Medi-Cal Mental Health, Behavior Health Treatment for Autism, and Substance Use Disorder Services, Referral and Coordination of Services* stated that the Plan's Director of Compliance and Regulatory Affairs in collaboration with the Plan's Medical Director and Director of Provider Network Development and Services will implement monitoring no less than quarterly during the first year of implementation and no less than annually thereafter. Monitoring will include but is not limited to the areas of claims, referrals, call center statistics, grievances and appeals. The Plan's Director of Provider Network Development and Services, the Plan's Care Coordination Manager, and the Plan's Chief Medical Officer shall review reporting of referrals, communicate a summary of the report, and highlight any cases of concern to the Chief Medical Officer (CMO).

The Plan's delegation agreement with the behavioral health subcontractor stated that the Plan will review subcontractor's utilization management (UM) program, UM Work Plan, policies and procedures and provide feedback as part of the annual oversight audit. In this agreement, the behavioral health subcontractor agreed to arrange for and manage the provision of medically necessary outpatient mental health services to adults and children diagnosed with a mental health condition resulting in mild to moderate impairment of mental, emotional, or behavioral functions.

The Plan did not continuously monitor and evaluate its delegated UM functions to ensure accountability. During the audit period, the Plan did not conduct an annual audit of UM activities delegated to a subcontractor. The Plan's oversight audit included a review of claims and grievances and but did not include a review of the subcontractor's UM activities.

The Plan's policies and procedures for subcontractor oversight contained invalid timeframes regarding the frequency of oversight reporting and monitoring. California Code of Regulations Title 28 requires delegates to report to the Plan at least quarterly, while the Plan's policies and procedures only required annual monitoring after the initial year of implementation. The Plan had a consultant working with the CMO to discuss UM processes; however, there was no formal or systematic reporting regarding the subcontractor's activities to the UM or quality improvement (QI) committees. Committee meeting minutes for the UM and QI department did not address oversight of the Plan's delegated functions. The Plan did not have a system in place to ensure that quarterly reports were received and reviewed within the Plan to identify deficiencies and areas of improvement.

Without continuous monitoring and oversight, the Plan cannot ensure that the behavioral health subcontractor meets the standards set forth in the Contract.

### 1.5.2 Pre-delegation audit of a delegated entity

The Plan is required to maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities, and ensures subcontractor meets the standards set forth by the Plan and DHCS. *(Contract A18, Exhibit A, Attachment 4, 6(B))*

The Plan may enter into subcontracts with other entities in order to fulfill obligations of the Contract. When doing so, the Plan shall evaluate the prospective subcontractor's ability to perform the requested services. *(Contract A18, Exhibit A, Attachment 6(13))*

The Plan did not evaluate the prospective subcontractor's ability to perform the requested services prior to the implementation of the delegation agreement.

During the Plan's Commission (Board) Committee meeting on November 9, 2016, the Plan selected a subcontractor for behavioral health treatment or applied behavioral analysis (ABA) for children with autism spectrum disorders. The Plan's delegation agreement was signed on January 9, 2017, with an implementation date of February 1, 2017. The Plan began conducting an audit of the subcontractor after the beginning of the service agreement. Between February 6 and March 31, 2017, the Plan reviewed the subcontractor's UM program description, reviewed the UM policies and procedures, provided feedback regarding UM documents, established committee planning meetings, and reviewed subcontractor's QI program description. The Plan did not finish its initial review of the subcontractor until 2 months after the beginning of the delegation agreement.

The Plan did not have policies and procedures in place to address conducting a pre-delegation audit of potential delegated entities.

The Plan stated that the initiative to delegate behavioral health treatment or applied behavioral analysis (ABA) for children with autism spectrum disorders came from a deficiency identified in a separate state audit. The Plan entered into a delegation agreement with the subcontractor without first conducting an evaluation of the subcontractor's ability to perform delegated activities.

If an initial review of a subcontractor is not done, the Plan will not be aware of the delegates' ability to perform and execute the duties as listed in the delegation agreement.

**RECOMMENDATION(S):**

**1.5.1** Implement policies and procedures to continuously monitor and evaluate the UM delegated functions.

**1.5.2** Develop policies and procedures to evaluate prospective subcontractor's ability to perform the requested services prior to delegation of services.

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## CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

| 3.6 | ACCESS TO PHARMACEUTICAL SERVICES |
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**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 FINDING(S):**

### 3.6.1 Members' access to drugs in emergency situations

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

Plan *Policy # HS-11: Oversight of Emergency Department's Methods for Ensuring Adequate Dispensing of Drugs*, stated it would monitor emergency departments (ED) by selecting a sample of 30 visits for chart review each quarter to determine if there were medications indicated and, if they were provided. The policy also stated that all EDs at the contracted hospitals or medical centers shall have a policy and procedures which address the contract requirement of providing an adequate amount of medication specifically at least a 72-hour supply of a covered outpatient drug in an emergency situation.

The Plan did not demonstrate that it monitored contracted hospitals or medical centers to ensure that emergency departments have policies and procedures in place related to emergency medication dispensing.

In the prior audit in 2016, the Plan did not request a statement from emergency departments that they had a policy of adequate access to drugs nor did the Plan conduct any audits of emergency departments with respect to their policies and procedures. In response to the 2016 audit finding, the Plan submitted a template document that requested a signature from the medical director to attest that a policy and procedure was in place but no actual attestations were provided.

During the 2017 audit, it was noted that Plan *Policy #HS-11 revision 8* dated 4/3/2017 continued to include the monitoring step to request on a periodic basis an attestation from medical directors that they had a policy and procedure to ensure that members receive sufficient supply of drugs in emergency situations.

However, Plan *Policy #HS-11 revision 9* dated 9/21/2017 excluded the step to request for attestations from medical directors at the emergency departments and did not address how the Plan will ensure EDs have policies and procedures in place to provide adequate amounts of medication in emergency situations. In interviews with the Plan, staff stated that the Plan intentionally excluded the attestation requests since they felt that the monitoring through quarterly review of sample ED visits was sufficient.

When the Plan does not monitor if contracted hospitals or medical centers have policies and procedures in place related to emergency medication dispensing, members are at risk of not receiving an adequate supply of medication in emergency situations.

**This is a repeat finding.**

**RECOMMENDATION(S):**

**3.6.1** Develop and implement a procedure to monitor contracted providers with emergency departments to ensure that a policy and procedure is in place for members to have access to at least 72-hour supply of drugs in emergency situations.

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## CATEGORY 4 – MEMBER'S RIGHTS

| 4.1 | GRIEVANCE SYSTEM |
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**Member Grievance System and Oversight:**
Contractor shall implement and maintain a Member Grievance system in accordance with Title 28 CCR Section 1300.68 (except Subdivision 1300.68(c)(g) and (h)), 1300.68.01(except Subdivision 1300.68.01(b) and (c)), Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, paragraph D.13, and 42 CFR 438.420(a)(b) and (c). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's health condition requires, within 30 calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written member notice.
COHS Contract A.14.1

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

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

**SUMMARY OF FINDING(S):**

### 4.1.1 Review of quality of care grievances

The Plan's medical director is required to resolve grievances related to medical quality of care. Resolved means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the Plan's grievance system, including entities with delegated authority. If the Plan has multiple internal levels of grievance resolution or appeal, all levels must be completed within 30 calendar days of the Plan's receipt of the grievance. *(Contract A18, Exhibit A, Attachment 1 (6) (E)) (CCR, Title 28 1300.68(a) (4)(A))*

Plan *Policy #: GA-07: Member Grievance Procedure for Non-Medicare Lines of Business* dated 7/1/2017 stated, "A case may not be closed until all issues in the grievance have been fully resolved. A resolution letter should not include a promise to the member that further follow up will be conducted regarding the grievance. If further follow up is required to fully resolve all issues, the case cannot be closed."

The Plan did not have a medical director review quality of care grievances prior to sending resolution letters.

During interviews, Plan staff confirmed that for quality of care grievances the process included an intake summary, sending an acknowledgement to member and provider, requesting a provider response as well as medical records, obtaining the provider response, completing a case review checklist and finally sending a resolution letter. The grievances were evaluated by the quality nurse for initial clinical review who then forwarded the grievance to a medical director for a separate potential quality incident (PQI) review. This was a separate process which the Plan stated was done in order to keep this portion confidential. There was no evidence that the medical director reviewed the quality of care grievances prior to sending a resolution letter.

The verification study showed that 13 of 13 sampled quality of care grievances were not reviewed by a medical director prior to sending the resolution letters. The resolution letters for quality of care grievances stated, "The Plan's Medical Director will review your case. If it is necessary, your case may also be reviewed by a physician peer review committee (a committee of doctors). Please understand this review will remain confidential. We apologize that we cannot share the results with you. Please be assured that we will take appropriate action to address any problems found." The Plan's process for resolving quality of care grievances did not comply with contract requirements nor with its own policy and procedures.

If quality of care grievances are not evaluated by a medical director in a timely manner, the Plan risks missing a potential quality of care issue which could be detrimental to the members' health and well-being.

### 4.1.2 Provider manual

There shall be a well-publicized appeals procedure for both providers and members. The Plan is required to issue a provider manual and updates to the providers of Medi-Cal services. The provider manual shall include the member's right to file grievances and appeals and their requirements and timeframes for filing. The Plan is required to provide all new members with written member information including the requirements and timeframes to filing a grievance or appeal. *(Contract A18, Exhibit A, Attachment 7(4))*

All Plan Letter *(APL) 17-006* titled, *Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments* dated May 9, 2017 states, "While existing state regulations establish a timeframe of at least 180 calendar days from the date of the incident subject to the beneficiary's dissatisfaction, new federal regulations allow grievances to be filed at any time."

The Plan did not update its provider manual to include the new timeframes for filing grievances that became effective July 1, 2017.

While DHCS was onsite, Plan staff confirmed that the provider manual had not been updated. The Final Rule updates were not incorporated into the provider manual. The Plan developed corrective action plans during the onsite and submitted its updated provider manual after the audit onsite was completed. The auditor reviewed the submission and confirmed the timeframe for filing grievances was still incorrect. The provider manual still stated 180 calendar days to file a grievance instead of any time.

If the provider manual is not updated with current information, such as with new timeframes on when to file grievances, members may be prevented from exercising their right to file a grievance.

**RECOMMENDATION(S):**

**4.1.1** Implement policy and procedures to assure that all levels of a grievance are resolved prior to sending a resolution letter to members.

**4.1.2** Develop and implement policy and procedures to ensure that correct timeframes to file a grievance are reflected in the provider manual.

| 4.3 | CONFIDENTIALITY RIGHTS |
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**Health Insurance Portability and Accountability Act (HIPAA) Responsibilities**:
**A. 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:

| ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖ |
|---|
| **PLAN:** San Mateo Health Commission dba Health Plan of San Mateo |
| **AUDIT PERIOD:** November 1, 2016 through October 31, 2017<br>**DATE OF AUDIT:** November 27, 2017 through December 8, 2017 |

| 4.3 | CONFIDENTIALITY RIGHTS |
|---|---|

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 FINDING(S):**

### 4.3.1 Privacy security incident DHCS notification timeframe

The Plan is required 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 Contract and Addendum, or potential loss of confidential data affecting the Contract. The Plan shall immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, the Plan shall submit an updated "DHCS Privacy Incident Report." *(Contract A18, Exhibit G, III (J)(1); Exhibit G, III (J)(2))*

Plan *Policy #: CD.01, Privacy Incident Investigation and Reporting* indicates that reports to DHCS must be made initially within 24 hours of discovery using the Privacy Incident Report (PIR) form. An updated PIR must be sent to DHCS within 72 hours of the initial report.

The Plan did not submit an updated "DHCS Privacy Incident Report" within 72 hours of discovery of a breach or security incident. Three of ten suspected security incidents did not have an updated PIR submitted to DHCS within 72 hours.

In the prior audit in 2015, the Plan did not notify DHCS of suspected security incidents within the required timeframe as detailed in its breach notification procedures. As part of the corrective action plan, the Plan had modified its policy to report all suspected security incidents to DHCS within 24 hours or 1 business day, and an updated PIR within 72 hours. However, the policy still reflected the incorrect timeframe as "within 72 hours of the initial report" instead of "within 72 hours of the initial discovery."

By ensuring that the Plan consistently reports all privacy breaches and security incidents to the DHCS Privacy Officer and Information Security Officer, the Plan will meet both its contractual and regulatory requirements in safeguarding the privacy of members' protected health information.

**This is a repeat finding.**

**RECOMMENDATION(S):**

**4.3.1** Revise and implement policy and procedures to comply with the required PIR reporting timeframe.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

**AUDIT PERIOD:** November 1, 2016 through October 31, 2017
**DATE OF AUDIT:** November 27, 2017 through December 8, 2017

## CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

| 6.3 | FRAUD AND ABUSE |
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**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) 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 FINDING(S):**

### 6.3.1 Suspected fraud and abuse incidents reporting timeframe to DHCS

The Plan is required to report all cases of suspected fraud or abuse where there is reason to believe that an incident of fraud or abuse has occurred by subcontractors, members, providers, or employees to DHCS. The Plan shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud or abuse within 10 working days of the date Plan first becomes aware of, or is on notice of, such activity. *(Contract A18, Exhibit E, Attachment 2 (27) (4))*

The definition of abuse per the contract states, "Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program." *(Title 42 CFR 455.2 and as further defined in Welfare and Institutions Code 14043.1(a))*

Plan *Policy#: CD.02: FWA Investigation and Reporting* states that in accordance with the main contract Exhibit E, Attachment 2, Section 27(B)(4), compliance staff file all suspected fraud, waste and abuse (FWA) cases with the Member Rights and Program Integrity Unit (MRPIU) of DHCS using the Medi-Cal Complaint Report (MC609) reporting template. Reports are made no later than 10 working days of when the Plan first becomes aware or is notified of FWA activity.

The Plan did not consistently report cases of suspected fraud or abuse to DHCS, nor the results of a preliminary investigation of suspected fraud within 10 working days of when the Plan first became aware of such activity. In the current audit period, six of ten suspected fraud or abuse cases were not reported to DHCS. Four of ten suspected fraud or abuse cases were reported, but two of those four exceeded the 10- working-day requirement to report the results of a preliminary investigation.

As part of the fraud, waste and abuse program, the Plan used a third party contractor to conduct compliance audits of two providers with potential overbilling concerns. The Plan determined that those providers overbilled based on its review of claims and medical records. Although funds were recovered from the providers, no report was submitted to DHCS regarding these suspected fraud and abuse incidents.

In the prior audit finding in 2015, the Plan did not notify DHCS of the results of its preliminary investigation of suspected fraud within 10 working days. As part of the corrective action plan, the Plan modified its desktop procedures, Plan Policy #CD.02 FWA Investigation and Reporting, to reflect the 10-working-day requirement for fraud, waste, and abuse cases to be investigated and reported to DHCS. Although the updated policy reflected the correct reporting timeframe, the Plan did not adhere to its procedures.

When procedures that are part of the Plan's anti-fraud and abuse program are not implemented, the Plan increases its exposure to fraud and abuse that could have been detected, investigated, and prevented.

**This is a repeat finding.**

**RECOMMENDATION(S):**

**6.3.1** Implement policies and procedures to report all cases of suspected fraud or abuse where there is reason to believe that an incident of fraud or abuse has occurred and report the results of the preliminary investigation of all suspected fraud or abuse cases to DHCS within 10 working days.

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

REPORT ON THE MEDICAL AUDIT OF

# San Mateo Health Commission
# dba Health Plan of San Mateo

Contract Number: 08-85220
State Supported Services

Audit Period: November 1, 2016
Through
October 31, 2017

Report Issued: May 24, 2018

# TABLE OF CONTENTS

# I. INTRODUCTION

This report was created for informational purposes. Department of Health Care Services (DHCS) did not conduct a review of the San Mateo Health Commission dba Health Plan of San Mateo (HPSM) State Supported Services contract No. 08-85220. The State Supported Services contract covers contracted abortion services with HPSM. Prior findings for State Supported Services not reviewed in the 2017 audit will be reviewed in a future audit.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

**PLAN:** Health Plan of San Mateo

**AUDIT PERIOD:** November 1, 2016 through October 31, 2017
**DATE OF AUDIT:** November 27, 2017 through December 8, 2017

## CATEGORY 1 - UTILIZATION MANAGEMENT

### 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 FINDING(S):**

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

**RECOMMENDATION(S):**
N/A