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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

May 22, 2018

Scott Coffin, CEO
Alameda Alliance for Health
1240 South Loop Road
Alameda, CA 94502

RE: Department of Health Care Services Medical Audit

Dear Mr. Coffin:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an initial on-site Medical Audit of Alameda Alliance for Health, a Managed Care Plan (MCP), from June 27, 2016 through July 7, 2016. Additionally, DHCS conducted expanded onsite reviews in intervals from February 7, 2017 through May 9, 2017. The audit covered the period of June 1, 2015 through May 31, 2017.

On May 14, 2018, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report issued on January 23, 2018.

All items have been reviewed and DHCS accepts the MCP's submitted CAP. The CAP is hereby closed. Full implementation of the CAP will be monitored on the subsequent audit. 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 me at (916) 552-8946 or Lyubov Poonka at (916) 552-8797.

Sincerely,

Hannah Robins, Chief
Compliance Unit

Enclosures: Attachment A CAP Response Form

cc: Laura Briones, 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: Alameda Alliance for Health

Audit Type: Medical Audit and State Supported Services **Review Period: 06/01/15 – 05/31/17**

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.

Deficiency Number and Finding	**Action Taken**	**Supporting Documentation**	**Implementation Date*** (*anticipated or completed)	**DHCS Comments**
1. Utilization Management				
1.4.1 Plan policy MED-CGR-0001, Member Grievances and Appeals, states that upon an appeal, the initial reviewer may be consulted when new	The Plan has created policy and procedure G&A-008 Adverse Benefit Determination Appeal Process that replaced the previous policies and procedures (MED-CGR-001 and MED-CGR-0025). The policy and procedure was approved by	1.4.1A-G&A-008 Adverse Benefit Determination Appeal Process	8/24/17	**02/26/18** – The following documentation supports the MCP's efforts to correct this finding: - P&P "G&A-008: Adverse Benefit

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information is presented that may cause the initial reviewer to reverse their original denial. It contradicts a different section of the same policy that states the Plan shall not allow a person previously involved in a prior decision to review the appeal of that decision	Committee on 8/24/17. As of 8/24/17, appeal cases are reviewed for final decision by a reviewer that was not involved in the prior adverse decision.			Determination Appeals Process" (08/24/17) which replaces the previous policies and includes language indicating that the "MCP appoints a reviewer that was not involved in the prior adverse decision to review the appeal. The reviewer will be neither the individual who made the adverse determination nor a subordinate of such individual" (#6, page 2). **This finding is closed.**
2.5.1 The Plan did not ensure the provision of CCM services to eligible members. The Plan did not fully implement their policies and procedures regarding the contact,	The Plan updated its policy and procedure CM-004 Care Coordination of Services. The policy and procedure was approved by Committee on 1/04/18. The Plan conducted a reconciliation review of all the cases in the case management system and closed all cases that met closure	2.5.1A-CM-001 Identification Screening Assessment and Triage 2.5.1B-CCM-004 Care Coordination of Services	2/27/18	**02/22/18** – The following documentation supports the MCP's efforts to correct this deficiency: - The MCP developed policy and procedure CM-006, "Internal Audit

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assessment, and triage of potential members who would benefit from the CCM program.	criteria as of 11/30/17. Staff training of the CCM policies and procedures (CM-001 and CCM-004) will be completed by 2/27/18 to review the processes for outreach, assessment, and triage of potential members who would benefit from the CCM program.	2.5.1C-CCM Reconciliation Report		and Monitoring" (1/4/18). The P&P states that staff will review 5 random CCM files per reviewer and assess for timeliness of assessments. DHCS sent a follow-up inquiry on 03/08/18 to inquire on the frequency of the audits. **03/14/18** – The following additional documentation supports the MCP's efforts to correct this deficiency: - Training materials and sign in sheet from Case Management Policy and Procedure training held on 3/9/18. The training touched on the findings from the audit as well as the revised and newly created Case

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				Management Policies and Procedures. - Revised Criteria for Case Management was created to streamline referral sources and to provide guidance for potential referrals. - CCM Monthly Dashboard Report is used to monitor referral sources, total active cases, completed assessments, active participation rate, and the case closure reasons. **04/05/18** - The following additional documentation supports the MCP's efforts to correct this deficiency: - CCM Aging Report dated 4/4/18 tracks the

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
				number of days each case is open as well as contact attempts. **This finding is closed.**
2.5.2 The Plan did not implement its policy to monitor its CCM program. The Plan did not identify cases that were not closed within 90 days.	The Plan created policy and procedure CM-006 Internal Audit and Monitoring to expand on its monitoring and oversight processes of the CCM program. The policy and procedure was approved by Committee on 1/04/18. Staff training of the updated policy and procedure was conducted on 2/12/18. As of 2/12/18, the Plan reviews production reports and dashboards to ensure appropriate monitoring and oversight of cases management activities.	2.5.2A-CM-006 Audit and Monitoring 2.5.2B-CM Reports Oversight & Monitoring Training Material 2.5.2C-CM Training Sign In Sheet 2.12.18 2.5.2D-CCM Production and Dashboard Reports	2/12/18	**02/22/18** – The following documentation supports the MCP's efforts to correct this deficiency: - "Care Management Management Oversight and Monitoring" PowerPoint training and corresponding sign in sheet (02/12/18) serve as evidence the two DM/CM managers received training on the MCPs new oversight and monitoring procedures. - MCPs written response and various sample reports that serve as evidence the MCP

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				developed methods to actively monitor its case management program. • Productivity Reports (12/05/17) that specifically address referrals, active cases, active participation rate and case closure for complex case management on a monthly basis. • Staff Performance Monitoring Reports (02/12/18) allows the monitoring of case management activities by assigned case manager on a daily basis.

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				04/05/18 - The following additional documentation supports the MCP's efforts to correct this deficiency: - CCM Aging Report dated 4/4/18 tracks the number of days each case is open as well as contact attempts. **This finding is closed.**
2.5.3 The Plan did not ensure PCP participation in the provision of CCM to each eligible member.	The Plan updated its policy and procedure CM-002 Complex Case Management Plan Development and Management to expand on PCP participation in the CCM program. The policy and procedure was approved by Committee on 1/04/18. As of 2/12/18, the Plan's processes with PCP participation have been implemented. The Plan will be conducting outreach to all PCPs to educate them on the Plan's CCM program by 2/28/18.	2.5.3A-CM-002 Complex Case Management Plan Development and Management 2.5.3B-PCP CCM Program Outreach Notice	2/28/18	**02/22/18** – The following documentation supports the MCP's efforts to correct this deficiency: - CCM Program Outreach Notice was created by the MCP to educate PCPs on the MCP's CCM program. **04/29/18** – The following additional documentation supports

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				the MCP's efforts to correct this deficiency: - Policy CM-002 Complex Case Management Plan Development and Management (Revision date 01/04/18) was updated to require PCP input in the development of the care plan. A draft care plan is submitted to the PCP with a request to review and provide input for the final care plan. - CCM PCP letter was revised to solicit input from the PCP in the development of the final care plan. The letter includes the draft care plan and a request for the PCP to review and provide input for the final care plan.

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				This finding is closed.
3. Access and Availability of Care				
3.1.1 The Plan did not consistently implement appropriate corrective action when providers did not comply with timely access standards.	The Plan revised its policy and procedure QM-114 Monitoring of Access and Availability Standards to expand on the Provider Appointment Availability Survey Corrective Action Plan (CAP) process. The revised policy and procedure will be reviewed for approval by Committee on 3/01/18. The Plan will notify a sub-set of the identified non-compliant providers of their results and the timely access standard requirements by 3/09/18. Non-compliant providers will be re-surveyed by 3/31/18. Providers found as non-compliant in the resurvey process will be issued a corrective action by 4/06/18 to address the deficiency of appointment access found.	3.1.1A-QM-114 Monitoring of Access and Availability Standards 3.1.1B-Provider Appointment Availability Survey Analysis 3.1.1C-Provider Notice of Non-Compliance & Resurvey Process	4/06/18	**02/26/18** – The following documentation supports the MCP's efforts to correct this deficiency: -Updated P&P, "QM-114: Monitoring of Access & Availability Standards (03/01/18) which has been amended to address follow-up actions and CAP issuance for non-compliant providers (page 5). -Access & Availability Subcommittee meeting (02/28/18) as evidence MCP discussed results of the 2017 After-Hours Availability Survey.

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				Recommendations by the committee were made to send letters to all non-compliant providers. (NOTE: DHCS noted a high rate of non-compliance. Follow-up inquiry was sent to MCP to inquire whether all non-compliant providers were receiving a letter and re-survey or just a subset.) -"Provider Appointment Availability Requirements & Survey Process" sample letter template which reminds non-compliant providers of the appointment standards and informs them that a follow-up survey will be conducted 03/19/18-03/23/18 to re-measure compliance.

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				05/14/18 – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: -Email (05/14/18) which includes updates on its survey and corrective action process for meeting timely access. MCP is currently assessing provider office appointment wait times and re-assessing non-compliant providers from the 2017 appointment availability survey. Continued non-compliant providers will be issued corrective action by 10/1/18. -Sample CAPs addressing first pre-natal appointments and after-hours access as evidence the MCP is

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				monitoring and implementing appropriate corrective action for addressing timely access compliance. **This finding is closed.**
3.1.2 The Plan did not initiate and implement steps to monitor member wait times at provider's offices and wait times to answer and return telephone calls.	The Plan revised its policy and procedure QM-114 Monitoring of Access and Availability Standards to include the methodology utilized to monitor provider office wait times. The Plan utilizes two methods to monitor provider wait times; a member survey process and through routine grievance data analysis. As per Policy QM-114, non-compliant providers will be notified about their excessive wait time found by the Plan. Providers who continue to have excessive office wait time or repeat grievances for telephone practices during subsequent review will be required to address their lack of timely standard requirements. The revised policies and procedures will be reviewed for	3.1.1A-QM-114 Monitoring of Access and Availability Standards 3.1.2A-Provider Wait Time Reports	3/23/18	**02/22/18** – The following documentation supports the MCP's efforts to correct this deficiency: -Updated P&P, "QM-114: Monitoring of Access & Availability Standards" (03/01/18) which has been updated to incorporate use of a quarterly "Clinician and Group Assessment of Healthcare Providers" (CG-CAHPS) to assess in office appointment wait times and telephone practices.

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	approval by Committee on 3/01/18. The provider wait time reporting will be reviewed by Committee on 3/01/18. Notification to non-compliant providers will occur by 3/23/18.			-Corresponding "Provider Wait Time Report," "Primary Care Wait Time Report," and excerpt of "CG-CAHPS" (10/17) as evidence MCP is following its P&P and has conducted monitoring of in-office wait times. -"Alliance Access Grievance Data" 2017 as evidence MCP is analyzing grievances by access type, including office wait times and telephone access by provider. **03/26/18** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency:

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				-Provider email blast, titled, “Timely Access Requirements” which is addressed to providers and staff and outlines timely access standards for appointment types, including returning member phone calls (2 business days). -Updated P&P, “QM-107: Appointment Access & Availability” (Draft) which has been amended to include in office wait times (shall not exceed 30 minutes) and returning telephone calls for non-urgent issues (within 2 business days). It further outlines how providers will comply with the standards. **This finding is closed.**

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3.1.3 The Plan did not monitor the initial prenatal visit appointment availability. The Plan's policies and procedures did not address monitoring of initial prenatal visit appointment availability.	The Plan revised its policy and procedure QM-114 Monitoring of Access and Availability Standards and QM-116 Appointment Access and Availability Standards to clarify the addition of OB/GYN provider appointment review and initial prenatal appointment timeliness standards. The policies and procedures will be reviewed for approval by Committee on 3/01/18. The Plan will notify the identified non-compliant providers of their results and the timely access standard for initial prenatal appointment availability requirements by 3/09/18. Non-compliant providers will be re-surveyed by 3/31/18. Providers found as non-compliant in the resurvey process will be issued a corrective action by 4/06/18 to address the deficiency of appointment access found.	3.1.1A-QM-114 Monitoring of Access and Availability Standards 3.1.3B-QM-116 Provider Appointment Availability Survey 3.1.3C-QM-107 Appointment Access and Availability Standards 3.1.1B-Provider Appointment Availability Survey Analysis 3.1.1C-Provider Notice of Non-Compliance & Resurvey Process	4/06/18	**02/22/18** – The following documentation supports the MCP's efforts to correct this deficiency: -Updated P&P, "QM-114: Monitoring of Access & Availability Standards (03/01/18) which has been amended to include details on monitoring initial prenatal appointments via the PAAS that will ensure compliance with the two week appointment access standard. -Updated P&P, "QN-116: Provider Appointment Availability Survey (PAAS)" which was designed to monitor provider compliance with access and availability standards,

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				including initial prenatal visit appointment to ensure availability is within two weeks from the date of request. **02/27/18** – The following documentation supports the MCP's efforts to correct this deficiency: -Written email clarifying that MCP has not yet conducted an assessment for the first prenatal appointment as the last PAAS did not incorporate assessment of that measure, specifically. However, MCP will specifically be measuring this during the survey scheduled for 03/19/18-03/23/18. DHCS to conduct follow-up on the subsequent audit to ensure MCP

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				assessed compliance with the first pre-natal appointment as required. **This finding is closed.**
3.3.1 The Plan did not implement appropriate corrective action when providers were found to be unavailable for after-hours calls.	The Plan revised its policy and procedure QM-114 Monitoring of Access and Availability Standards to expand the processes with corrective action implementation and follow up. The updated policy and procedure will be reviewed for approval by Committee on 3/01/18.The Plan conducted an After-hours survey and results will be reported to Committee on 3/01/18. Providers found non-compliant with high priority deficiencies will be issued a corrective action by 3/23/18.	3.1.1A-QM-114 Monitoring of Access and Availability Standards 3.3.1A-Provider After Hours Survey Report 3.3.1B-After-Hours Survey Analysis	3/23/18	**02/22/18** – The following documentation supports the MCP's efforts to correct this deficiency: -Updated P&P, "QM-114: Monitoring of Access & Availability Standards" (03/01/18) which indicates the MCP annually conducts an after-hours survey to monitor compliance with after-hours care (page 3). P&P commits MCP to outreach non-compliant providers regarding deficiencies that require corrective action. -Access & Availability Subcommittee meeting

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				(02/28/18) as evidence MCP discussed results of the 2017 After-Hours Availability Survey. Recommendations by the committee were made to send letters to all non-compliant providers. **05/14/18** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: -Sample CAP as evidence that the MCP is monitoring timely access standards and issuing appropriate corrective action to non-compliant providers regarding after-hours access. **This finding is closed.**

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4. Members' Rights				
4.1.1 The Plan did not consistently refer quality of care grievances to the medical director for oversight and resolution.	The Plan has created a new policy and procedure G&A-003 Grievance Receipt, Review and Resolution. The policy and procedure was approved by Committee on 8/24/17. Staff training was conducted on 11/21/16 of the clinical review process. Grievance process checklist tools were created for processing grievances and have been fully implemented as of 8/24/17.	4.1.1A-G&A-003 Grievance Receipt, Review and Resolution 4.1.1B-Expedited Grievance Check List 4.1.1C-Standard Grievance Check List 4.1.1D-Grievance Clinical Review Training 4.1.1E-Grievance Clinical Review Staff Training Sign In Sheet 11.21.16	8/24/17	**02/23/18** – The following documentation supports the MCP's efforts to correct this finding: - New P&P, "G&A-003: Grievance Receipt, Review and Resolution" (08/24/17) which has been created to include a section which states that all grievances related to medical quality of care issues are immediately submitted to the plan's medical director for action. **04/12/18** – The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "QM-104: Potential Quality Issues (PQIs)"

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				(04/12/18) which has been amended to address that all quality of care issues will be referred to the Medical Director for review (page 4). **This finding is closed.**
4.1.2 The Plan did not consistently apply the process of standard grievance and exempt grievance identification and processing as stated in the policies and procedures.	The Plan has created a new policy and procedure G&A-003 Grievance Receipt, Review and Resolution. The policy and procedure was approved by Committee on 8/24/17. Grievance staff training was conducted on 1/10/18 on the updated policy and procedure. The Plan updated its policy and procedure MBR-0024 Exempt Grievances that was approved by Committee on 1/04/18. Staff training for Member Services was conducted on 10/26/17 and 11/30/17 for reviewing the updated exempt grievance processes. As of 1/10/18, grievance and exempt grievance identification and processing are applied consistently and align with the	4.1.1A-G&A-003 Grievance Receipt, Review and Resolution 4.1.2A-MBR-024 Exempt Grievances 4.1.2B-Grievance and Appeals Intake Process 4.1.2C-Exempt Grievance System Staff Training 1.10.18 4.1.2D-Exempt Grievances Training Material 4.1.2E-Exempt Grievance Training	1/10/18	**02/23/18** – The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "MBR-024: Exempt Grievances" (01/04/18) which has been amended to include that exempt grievances shall be resolved within the close of the next business day following receipt of the complaint. If the exempt grievance is not fully resolved within this timeframe, it

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	Plan's policies and procedures.	Sign In Sheet 11.30.17 4.1.2F-Compliance Final Rule Training Material 4.1.2G-Final Rule Member Services Training Sign In Sheet 10.26.17		shall be processed as a standard grievance. - "Grievance and Appeals Intake – Member Services Department" flow chart which indicates that complaints that cannot be resolved within the next business day must be forwarded to the G&A unit. - PowerPoint Training, "Complaints and Resolutions" (01/05/18) and sign-in sheets as evidence that training was conducted. The training materials address how the plan must classify a call as a grievance if it cannot distinguish between a grievance and inquiry (slide 7). The training also requires the MSR to

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				reclassify an exempt grievance to a standard grievance if it cannot be resolved by the close of the next business day (slide 16 and 17). **This finding is closed.**
4.1.3 The Plan did not have a process for monitoring and reviewing grievances designated as non-clinical to ensure quality of care issues were not missed.	The Plan has created a new policy and procedure G&A-003 Grievance Receipt, Review and Resolution. The updated processes outline clinical involvement in all quality of care grievances. Grievance training of the clinical review was conducted on 11/21/16. The Plan has updated its' exempt grievance policy and procedure MBR-024 Exempt Grievances to ensure potential quality of care issues are identified and referred appropriately. The policy and procedure was approved by Committee on 1/04/18. Training was conducted for Member Services staff on the updated exempt grievance processes on 11/30/17. Potential quality issue identification and referral	4.1.1A-G&A-003 Grievance Receipt, Review and Resolution 4.1.1D-Grievance Clinical Review Training 4.1.1E-Grievance Clinical Review Staff Training Sign In Sheet 11.21.16 4.1.1B-Expedited Grievance Check List 4.1.1C-Standard Grievance Check List 4.1.2A-MBR-024 Exempt Grievances	1/04/18	**02/23/18** – The following documentation supports the MCP's efforts to correct this finding: - PowerPoint Training, "Potential Quality Issues (PQIs)" (11/30/17) and corresponding sign-in sheet as evidence MSRs were trained on how to identify PQIs and forward them to the QI Department for review and investigation. DHCS followed-up with the MCP to inquire about any oversight processes in place to ensure that

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	training was conducted for Member Services staff on 11/30/17.	4.1.3A-PQI Training Material Member Services 4.1.3B-PQI Training Sign In Sheet 11.30.17		MSRs are consistently forwarding all PQIs for review to QI staff. -Updated P&P, "MBR-024: Exempt Grievances" (01/04/18) which has been amended to include that the Quality Department's clinical team will assist in the annual review to ensure PQIs are appropriately identified and referred internally for further investigation. DHCS followed-up with the MCP to inquire about monitoring activities in place to ensure both MSRs and G&A coordinators consistently identify and forward PQIs to the appropriate clinical reviewer. **03/24/18** – The following documentation supports

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				the MCP's efforts to correct this finding: - MSR scorecard reports "Agent Scored Evaluation" (03/24/18) as evidence that the plan has an oversight and monitoring process in place to evaluate if the MSR is correctly identifying the classification of grievances. These reports include examples where a case should have been identified as a grievance and referred as PQI. Supervisors will also training trains the MSRs regarding reassigning cases properly. - Written email (03/24/18) clarifying that the plan's clinical nurses identify and forward

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				PQIs internally. The plan is in process of auditing calls and exempt grievances to ensure PQIs are identified and referred internally. **This finding is closed.**
4.1.4 Seven of 45 grievances reviewed showed the Plan sent member resolution letters without resolving the grievance.	The Plan has created a new policy and procedure G&A-003 Grievance Receipt, Review and Resolution. The policy and procedure was approved by Committee on 8/24/17. Grievance staff training was conducted on 12/27/17 on the updated policy and procedure.	4.1.1A-G&A-003 Grievance Receipt, Review and Resolution 4.1.1B-Expedited Grievance Check List 4.1.1C-Standard Grievance Check List 4.1.4A-Grievance System Staff Training 12.27.17	12/27/17	**02/23/18** – The following documentation supports the MCP's efforts to correct this finding: - MCP's written response (02/23/18} and "Grievance System Staff Training" attendance sign up list affirms that the staff training took place on 12/27/17. Attendance list supports the evidence of the training of five G&A coordinators and QA specialist.

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				- 4.1.1 “Standard Grievance check List” confirms that the training addressed procedures in the event grievance resolution was not reached within 30 calendar days. (page 2) -P&P “G&A-003 Grievance Receipt, Review and Resolution” shows MCP’s commitment to quarterly monitoring and staff training. (page 4). During internal audits an universe is requested the month after the end of the quarter, from which 30 files are reviewed. Audit findings are sent to the G&A manager and will be reported to the Compliance committee quarterly.

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				This finding is closed.
4.1.5 In seven grievances reviewed, the Plan did not notify the member in writing when a resolution to their grievance would not be reached within 30 days and did not provide an estimated completion date of resolution. The Plan only called to notify members that a follow-up would occur.	The Plan has created a new policy and procedure G&A-003 Grievance Receipt, Review and Resolution. The policy and procedure was approved by Committee on 8/24/17. Grievance staff training was conducted on 12/27/17 on the updated policy and procedure.	4.1.1A-G&A-003 Grievance Receipt, Review and Resolution 4.1.1B-Expedited Grievance Check List 4.1.1C-Standard Grievance Check List 4.1.4A-Grievance System Staff Training 12.27.17	12/27/17	**02/23/18** – The following documentation supports the MCP's efforts to correct this finding: - MCP's written response (02/23/18} and "Grievance System Staff Training" attendance sign up list affirms that the staff training took place on 12/27/17. Attendance list supports the evidence of the training of five G&A coordinators and QA specialist. - 4.1.1 "Standard Grievance check List" confirms that the training addressed procedures in the event grievance resolution was not reached within 30 calendar days. (page 2)

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
				- P&P "G&A-003 Grievance Receipt, Review and Resolution" shows MCP's commitment to quarterly monitoring and staff training. (page 4). During internal audits an universe is requested the month after the end of the quarter, from which 30 files are reviewed. Audit findings are sent to the G&A manager and will be reported to the Compliance committee quarterly. **This finding is closed.**
4.1.6 The Plan did not send acknowledgement or resolution letters to providers who submitted grievances on behalf of members.	The Plan has created a new policy and procedure G&A-001 Grievance System Description. The policy and procedure was approved by Committee on 8/24/17. Grievance staff training was conducted on	4.1.6A-G&A-001 Grievance System Description 4.1.1C-Standard Grievance Check List	12/27/17	**04/13/18** – The following documentation supports the MCP's efforts to correct this finding:

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	12/27/17 on the updated policy and procedure.	4.1.4A-Grievance System Staff Training 12.27.17		-“Standard Grievance Check list:G&A Coordinator” and “Expedited Grievance checklist: G&A Coordinator”. The checklists now include the procedure for sending acknowledgement letter for grievances submitted by the provider on behalf of the member. -Revised policy “G&A – 001 Grievance and Appeals System Description” and “G&A – 003 Grievance Receipt, Review and Resolution” policy is now clarifies that complainant such as someone on behalf of the member such as a provider would receive the resolution letter copy.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
				-"Grievance System Staff Training" (04/10/18) is attesting that the staff took the training on 04/10/18 to review changes added to the grievance checklists to meet DHCS requirements. **This finding is closed.**
4.3.1 The Plan did not have policies and procedures to address conducting background checks of employees before Plan employees are allowed access to PHI. The Plan did not consistently verify professional licenses for medical staff prior to their employment.	The Plan has created policies and procedures HR-015 Background Checks Procedure and HR-017 License Verification Reverification for ensuring all background checks as well as professional licenses for medical staff are appropriately checked prior to their employment at the Plan. The policies and procedures were approved by Committee on 12/14/17. The Plan tracks all new hired employees and existing employees to ensure their professional licenses are verified appropriately.	4.3.1A- HR-015 Background Checks Procedure 4.3.1B-HR-017 License Verification Reverification 4.3.1C-License Verification Tracking Log	12/14/17	**02/22/18** – The following documentation supports the MCP's efforts to correct this deficiency: - Updated P&P, "HR – 015: Background Check Procedure" (12/14/17) which has been revised to include a section on background checks for internal and external employees and applicants (all jobs). HR will check and document references, including verification of

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				professional license, driver's license and document references, including verification of professional license, driver's license and insurance when applicable. Upon receipt of completed background checks, HR will assess the results based on the outcome of the information and the time elapsed since the incident/offense and the relevance of the incident/ offense to the job. All background checks are reviewed and signed off by the Executive Director, Human Resources. Offenses/Incidents will be reviewed by the Executive Director, Human Resources and request judgment of Legal Counsel. Signed

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
				off background check with justification will be filed in the employee's Personnel File retained in strict confidence by HR. - Updated P&P, "HR-017: License Verification & Reverification" (12/14/17) which has been created to ensure that the MCP will verify license verification and re-verification for all new hires, promotions and transfers. HR will audit the licenses on a monthly basis to review license expirations coming up within 60 days. - License verification tracking log (01/01/18) which ensures that the MCP is tracking new hires & customer staff as

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				it relates to license verifications. The log consists of, Name, License/Cert, License/ Cert #, Issue date of license, expiration of license, reverification date, credential date and re-credential date. - Written Response (04/11/18): Per MCP, the contracted vendor HireRight is responsibe for completing full background checks. Upon receipt of completed background checks, HR will assess the results based on the outcome of the information and the time elapsed since the incident/offense and the relevance of the incident/ offense to the job.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
				This finding is closed.
5. Quality Management				
5.2.1 The Plan did not implement its policy or have controls in place to ensure the completion of new provider training within 10-working days.	The Plan has updated its policy and procedure PRV-001 New Provider Orientation to ensure appropriate controls are in place for tracking provider training completion within the required timeframe. The policy and procedure was approved by Committee on 12/14/17. As of 11/01/17, new providers contracted with the Plan are required to attest to training completion electronically within the required timeframe. As of 2/01/18, delegated entities responsible for the provider training are required to obtain signatures during the training and provide the Plan with the completed attestation.	5.2.1A-PRV-001 New Provider Orientation 5.2.1B-New Provider Orientation Attestation Workflow 5.2.1C- Delegate's New Provider Orientation Attestation Workflow	2/01/18	**02/26/18** – The following documentation supports the MCP's efforts to correct this finding: -Updated P&P, "PRV-001: New Provider Orientation" (12/14/17) which was amended to ensure controls are in place for tracking provider training. The Provider Relations Representative is responsible for ensuring all new providers (either directly contracted with the MCP or through its delegates) complete training within the required timeframe. In addition, the Provider Services department will monitor the list of newly

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
				contracted providers against the provider orientation log and delegates will be required to provide all documentation to the MCP. -Two distinct flow charts that include timeframes that must be met to ensure timely training for all new providers (either directly contracted with the MCP or through its delegates): • NPO Attestation/DocuSign Workflow • CHCN NPO Attestation/DocuSign Workflow (01/18/18) **03/21/18** – The following documentation supports

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
				the MCP's efforts to correct this finding: -"NPO Attestation Log" (01/05/18 – 03/14/18) as evidence that MCP has a monitoring system in place to track completion of provider training within the required timeframes and ensure receipt of signed/dated attestations. **This finding is closed.**
5.2.2 The Plan did not conduct provider training to newly contracted providers within 10-working days of placing a new provider on active status.	The Plan has updated its policy and procedure PRV-001 New Provider Orientation to ensure appropriate controls are in place for tracking provider training completion within the required timeframe. The policy and procedure was approved by Committee on 12/14/17. As of 11/01/17, new providers contracted with the Plan are required to attest to training completion electronically within the required timeframe. As of	5.2.1A-PRV-001 New Provider Orientation 5.2.1B-New Provider Orientation Attestation Workflow 5.2.1C- Delegate's New Provider Orientation Attestation Workflow	2/01/18	**02/26/18** – The following documentation supports the MCP's efforts to correct this finding: -Updated P&P, "PRV-001: New Provider Orientation" (12/14/17) which was amended to ensure controls are in place for tracking provider training. The

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
	2/01/18, delegated entities responsible for the provider training are required to obtain signatures during the training and provide the Plan with the completed attestation.			Provider Relations Representative is responsible for ensuring all new providers (either directly contracted with the MCP or through its delegates) complete training within the required timeframe. In addition, the Provider Services department will monitor the list of newly contracted providers against the provider orientation log and delegates will be required to provide all documentation to the MCP. -Two distinct flow charts that include timeframes that must be met to ensure timely training for all new providers (either directly contracted with the MCP or through its delegates):

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				• NPO Attestation/DocuSign Workflow • CHCN NPO Attestation/DocuSign Workflow (01/18/18) **03/21/18** – The following documentation supports the MCP's efforts to correct this finding: -"NPO Attestation Log" (01/05/18 – 03/14/18) as evidence that MCP has a monitoring system in place to track completion of provider training within the required timeframes and ensure receipt of signed/dated attestations. **This finding is closed.**

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6. Administrative and Organizational Capacity				
6.1.1 The Plan did not ensure qualified medical personnel were responsible for implementation of the Case Management Program	The Plan has updated its CCM job descriptions to ensure appropriate qualifications are included for the medical personnel staff position responsible for the CCM program.	6.1.1A-Complex Case Manager Job Description 6.1.1B-Case Management Manager Job Description	2/16/18	**02/22/18** – The following documentation supports the MCP's efforts to correct this deficiency: **-** Updated Duty Statements, "Complex Case Manager, Nurse" (02/28/17) and "Manager, Case & Disease Management" (8/25/16) which has been updated to include Requirements regarding education or training equivalent to: • BSN or MSN • RN license (active and unrestricted licensed in the State of California

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				- Updated P&P, "HR – 015: Background Check Procedure" (12/14/17) which has been revised to include a section on background checks for internal and external employees and applicants (all jobs). HR will check and document references, including verification of professional license, driver's license and insurance when applicable. Upon receipt of completed background checks, HR will assess the results based on the outcome of the information and the time elapsed since the incident/offense and the relevance of the incident/ offense to the job. All background checks are reviewed and signed off by the Executive

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				Director, Human Resources. Offenses/Incidents will be reviewed by the Executive Director, Human Resources and request judgment of Legal Counsel. Signed off background check with justification will be filed in the employee's Personnel File retained in strict confidence by HR. - Updated P&P, "HR-017: License Verification & Reverification" (12/14/17) which has been created to ensure that the MCP will verify license verification and re-verification for all new hires, promotions and transfers. HR will audit the licenses on a monthly basis to review license expirations

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
				coming up within 60 days. - License verification tracking log (01/01/18) which ensures that the MCP is tracking new hires & customer staff as it relates to license verifications. The log consists of, Name, License/Cert, License/ Cert #, Issue date of license, expiration of license, reverification date, credential date and re-credential date. **This finding is closed.**
6.3.1 The Plan did not report all suspected cases of fraud and/or abuse to DHCS within 10-working days.	The Plan has updated its policies and procedures CMP-002 Fraud, Waste, and Abuse and CMP-003 False Claims Act to ensure all suspected fraud and abuse cases are reported to DHCS within the 10 working day timeframe. The updated policies and procedures were approved by	6.3.1A-CMP-002 Fraud, Waste, and Abuse 6.3.1B-CMP-003 False Claims Act 6.3.1C-2018 Alliance Anti-Fraud Plan	1/23/18	**02/22/18** – The following documentation supports the MCP's efforts to correct this deficiency: - Updated P&P, "CMP-002: Fraud, Waste and Abuse (FWA)" (revised

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	Committee on 12/14/17. Staff training was conducted on 1/23/18 to review the updated policies and procedures for reporting all suspected fraud and abuse cases to DHCS. As of 1/23/18, the Plan reports all suspected cases of fraud and abuse to DHCS within the required timeframe and documents reporting through the Plan's tracking log.	6.3.1D-FWA Investigations Desktop Procedure 6.3.1E-FWA Compliance Training 1.23.18 6.3.1F-FWA training Sign In Sheet 1.23.18 6.3.1G-2018 FWA Incident Tracking Log		12/14/17) which has been revised to comply with the 2-Plan Contract E.2.26.B. P&P CMP-002 which states" "The Alliance's Compliance will report all suspected FWA incidents to the Department of Health Care Services (DHCS) within 10 working days of the date the Alliance becomes first aware or notified of the suspected activity. MCP also stated in P&P, CMP-002 that they will submit along with MC 609 the required reporting information along with the preliminary investigation summary. - Desktop Procedure, Fraud, Waste and Abuse (FWA) Investigations (1/23/18) as evidence

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				that the Compliance Auditor or Manager will immediately investigate the FWA case and gather all pertinent information from the reporting department or person. Then the Compliance Manager or Manager will forward the MC 609 to DHCS within 10 working days that MCP is first aware of an incident or is in notice of FWA activity. - PowerPoint training, "Fraud Waste & Abuse (FWA) Training" (1/23/18) and sign in sheet as evidence that customer staff received training. The training materials addressed FWA reporting requirements and how and what to report. The training materials are

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				consistent with the contractual requirements, 2-Plan Contract E.2.26.B. - 2018 FWA Investigation log, (1/02/18/) as evidence that the MCP is tracking incoming potential FWA incidents and ensuring that the preliminary investigations are being sent to DHCS within 10 working days. **This finding is closed.**

Submitted by: Scott Coffin **Date:** 2/22/18
Title: Chief Executive Officer