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

JENNIFER KENT
DIRECTOR

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GOVERNOR

May 25, 2018

Frank Lee, Director of Compliance and Governmental Relations
Contra Costa Health Plan
595 Center Avenue, Suite 100
Martinez, CA 94553

RE: Department of Health Care Services Medical Audit

Dear Mr. Lee:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Contra Costa Health Plan, a Managed Care Plan (MCP), from June 12, 2017 through June 22, 2017. The survey covered the period of May 1, 2016 through April 30, 2017.

On May 23, 2018, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on February 15, 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 AJ Martinez at (916) 552-8716.

Sincerely,

Hannah Robins, Chief
Compliance Unit

Enclosures: Attachment A CAP Response Form

cc: Marc Lewis, 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: Contra Costa Health Plan

Audit Type: Medical Audit and State Supported Services **Review Period: 05/01/16 – 04/30/17**

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: Ensure that appropriate timeframes for appeals acknowledgment and resolution letters are followed	1.4.1: Staff responsible for provider and member appeals has been counseled to ensure that appropriate timeframes are used for member appeals.	See Plan of Correction.	January 2, 2018	**04/18/18** – The following documentation supports the MCP's efforts to correct this finding: Note: Reviewed MCP's EOC online and verified timeframes for both acknowledgement and resolution letters are compliant with the new

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				requirements as stipulated by the final rule. -Updated P&P, “MS 8.018: Appeal Process for Medi-Cal Members Fair Hearing and Independent Medical Review Process” (06/06/17) which has been amended to comply with the timeframe requirements for acknowledgement and resolution notification as stipulated in the Final Rule and outlined in APL 17-006. Member services department has a log of pending appeals or those that are reaching the maximum time limit for completion that is reviewed daily to make sure timelines for response are tracked (CCLink system). -Final Rule training (Medi-Cal Only) and sign-in sheet (06/08/17) as evidence that staff received training. Training materials address changes in handling of grievances and appeals, including timeframes and applicable notices related to Notice of Appeals Resolution Letters.

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				-Plan of Correction (02/13/18) signed by staff responsible for processing member appeals acknowledging that they have been counseled on the appropriate timeframes for member appeals acknowledgement (5 days) and resolution letters (30days). 04/26/18 – The following additional documentation submitted supports the MCP's efforts to close this deficiency: -An email (04/26/18) which included a screen shot of the MCP's systems log that is monitored to ensure timeframe for acknowledgement and resolution are being met. **This finding is closed.**
1.4.2: Ensure that staff can properly categorize and process member and provider appeals.	1.4.2: In order to ensure that staff can properly categorized and process member and provider appeals, CCHP has revised our previously combined Appeals Charter to now have separate Member Appeals Charter to	UM15.009 UM15.031 Member Appeals Charter Provider Appeals Policy	January 2, 2018	**04/23/18** – The following documentation supports the MCP's efforts to correct this finding: -Updated P&P, "MS 8.018: Appeal Process for Medi-Cal Members Fair Hearing and Independent Medical Review Process" (06/06/17) which

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	protect member's appeal rights and a separate Provider Appeals and Dispute Policy to ensure that provider disputes are appropriately categorized and addressed. This will further clearly ensure that if a provider is submitting an Appeal or Payment dispute on behalf of the member, it will be expedited at the five (5) day timeline to acknowledge and 30 day timeline to reach resolution. Providers must have the member's permission in writing. This new Provider Appeals and Dispute Policy will also ensure that our providers are paid accurately and timely as well as clearly distinguish the provider appeal process from the member appeal process. For Provider issues of Medical necessity, they are sent to UM for the **Provider Appeal process.** When there is a dispute on Provider **Payment**			has been amended to comply with the timeframe requirements for acknowledgement and resolution notification as well as the consent requirements as stipulated in the Final Rule and outlined in APL 17-006. -Final Rule training (Medi-Cal Only) and sign-in sheet (06/08/17) as evidence that staff received training. Training materials address changes in handling of grievances and appeals, including timeframes, written consent requirements and applicable Notice of Appeals Resolution Letters. -Plan of Correction (02/13/18) signed by staff responsible for processing member appeals acknowledging that they have been counseled on the appropriate timeframes for member appeals acknowledgement (5 days) and resolution letters (30 days). -DHCS provided technical assistance to MCP and recommends MCP continues to ensure all medical

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	they are sent directly to the Claims Department. **Effective January 2, 2018** we will have implemented the following changes to our workflow for Provider Appeals and Disputes *: -All Provider Appeals, related to medical necessity, along with Medical Records will go to the UM Appeal Department -Any correspondence pertaining to Claim payment will be sent to the Claims Department for action (creating a CRM, sending appropriate actions to the providers, resolving the dispute) -Payment questions will not go to the UM Department because their role is to determine Medical Necessity -Revising the Provider Dispute Form that gives clear directions that Provider Appeals go to UM with the Medical Records and Provider Payment Dispute goes to Claims			necessity reviews involving clinical issues be resolved by a health care professional with appropriate clinical expertise in treating the Member's condition or disease. Additionally, DHCS recommends provider network outreach and/or training be conducted regarding member written consent requirements prior to processing of member appeals. Consideration should also be given to modifying applicable policies and procedures to include good faith efforts in obtaining a member's written consent when applicable. DHCS will continue its monitoring efforts to ensure MCP is compliant with all member appeal requirements. Progress on full implementation of corrective action will be assessed on the subsequent audit. **This finding is closed.**

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	--The new form will be posted to the CCHP Provider Portal by January 5, 2018 -We will aggressively implement a Training Program for our providers on the Appeals & Provider Dispute Process -Provider Appeals and Disputes process training will be to targeted providers who had double digit Appeals/Grievances in 2017 -Participate in Provider Joint Operations Meetings in 2018 educating providers on Appeals and Disputes Process We believe this process will ensure that the roles are clearly defined and we **communicate** to our providers on the status of their Provider Appeals and Payment Disputes. *Notes (a) No changes were made to the Member Grievances			

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	Process that is handled by Member Services and QM Nurses. (b) Provider Relations is no longer involved in either the Payment Dispute or Appeals process. They are only involved in Provider network and contracting issues.			
1.5.1: Continue implementation of annual oversight audits for plan's subcontractors.	1.5.1: CCHP has conducted the Behavioral Health Oversight audit.	Behavioral Health UM Audit Report and CAP. `	December 18-19, 2017	**04/02/18** - The following documentation supports the MCP's efforts to correct this finding: - Delegation Behavioral Health UM 2017 Audit Report and Corrective Action Plan serve as documentation that the MCP conducted an oversight audit on a subcontractor to which it delegates UM responsibilities for 2017 **04/20/18** - The following additional documentation supports the MCP's efforts to correct this finding: - In an email communication with MCP dated 4/20/18, it was confirmed that Contra Costa Behavioral Health

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				is scheduled to be audited in 2018. **This finding is closed.**
1.5.2: Continue to implement monitoring and oversight of delegated entities through the timely receipt and analysis of quarterly UM reports.	1.5.2: CCHP worked with Kaiser Foundation Health Plan, to ensure that CCHP receives a Quarterly UM Report for review by CCHP.	Q2-Q4 2017 Kaiser UM Reports are attached.	August 2017	**04/02/18** - The following documentation supports the MCP's efforts to correct this finding: - Kaiser UM Reports from Q1-Q3 2017 serve as evidence that the MCP is receiving UM reports from its delegated entities. **04/20/18** - The following additional documentation supports the MCP's efforts to correct this finding: - In an email communication from the MCP dated 4/20/18. The MCP confirmed that it will receive UM reports from Kaiser and BHT in 2018. CCRMC was de-delegated as of 1/31/17. **This finding is closed.**

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2. Case Management and Coordination of Care				
2.4.1: Develop and implement policies, systems, and training that direct and support compliance with the requirements regarding the provision of USPSTF "A" and "B" recommended preventive health services during the IHA/IHEBA.	2.4.1 The revised version of the Provider Manual Section 14 regarding Preventive Health Services is attached. We revised after the audit was done in June 2017. We will also add Preventive Services and Clinical guidelines as a standing agenda item at our Quarterly CPN meetings and list a link to the guidelines in every quarterly provider bulletin.	Provider Manual Section 14.	July 2017	**04/02/18** – The following documentation supports the MCP's efforts to correct this finding: -Revised Provider Manuel (June of 2017) to include a link to "Guide to Clinical Preventive Services" published by the U.S. Preventive Services Task Force (USPSTF) which provide a direct access for MCP's providers to provision of USPSTF "A" and "B" recommended clinical preventive services during the IHA/IHEBA and a link to "CCHP's preventive guidelines" which provide access for providers to MCP's updated preventive services guideline. (Section 14) In addition, in an email, MCP clarified: "during the audit, we had discussed with the Audit team the option of placing a link to the USPSTF recommended services, instead of listing each of the 39. At the time, the auditor's agreed and found this acceptable" **04/18/18** – The following additional

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				documentation submitted supports the MCP's efforts to correct this finding: -Meeting minutes from the Community Provider Network (CPN) quarterly meetings (01/23/18 & 04/17/18) which provides evidence of documented review and discussion of USPSTF latest clinical preventive services (A & B). Handout and sign in sheets were submitted. -A copy of Provider Bulletin "Community Provider Network – Care Matters" (Volume 15. Issue 2, summer 2017) as evidence that MCP informed providers of importance of offering IHA/IHEBA using latest USPSTF guideline. A link to USPSTF latest clinical preventive services was provided. In addition the bulletin offered tips for administering, documenting and completing these preventive services. (Pages 10 & 11) -Updated P&P, "9.816: Provider Training" (December of 2017) as evidence that MCP's new and current

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				providers receive trainings for all line of business including on how to administer, document and complete USPSTF latest guidelines for clinical preventive services during IHA/IHEBA. **This finding is closed.**
3. Access and Availability of Care				
3.5.1: Establish a reliable system to ensure continued training of claims staff and to establish a system to address current or potential quality issues within the claims department during operational meetings.	The Claims Department has created several new policies and procedures to ensure that staff are well trained to ensure top notch Claims Services. We initiated a series of trainings in 2017 to educate and review our processes for Payment Disputes with the Management/Team Leads to ensure all guidelines are concise. A series of six trainings were held to include Deep Dive sessions that drove changes to some of our practices. At these forums we are educating our Management staff and employ a train the trainer format so that during the	*(See attached file: 3.5.1 Deep Dive Claims & UM.pptx)* *(See attached file: 3.5.1 Deep Dive Claims & UM.pptx Session 2.pptx)* *(See attached file: 3.5.1 Claims Fourth Quarter Training.pptx)* *(See attached file: 3.5.1 Claims Training Compliance January 2018.pptx)*	July 2017	**04/02/18** – The following documentation supports the MCP's efforts to correct this finding: - PowerPoint training, "Claims Examiner Training" (01/31/18) as evidence that claims staff is aware of a new system to forward misdirected claims to the appropriate capitated provider within 10 working days. The training materials address that the plan met with Kaiser and is currently working on a solution to remedy this finding. The MCP is planning to connect Kaiser's Clearing House – Relay Health to CCHP's clearing house Docustream. Also, the plan will create an automatic connection with the 277 rejection process that takes

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	staff monthly meetings the Management Team shared these enhancements for Payment Disputes. Secondly, we launched Quarterly meetings to ensure our entire staff was aware of enhancements and to resolve issues. The Chief Operations Officers conducts these trainings. In one of our sessions we allowed the Claims Examiners Team to brainstorm on how to improve and automate some of our processes in which we will be implementing in Q4. Furthermore as part of our New Employees Orientation, as new Claims staff join our team we give a solid overview of Claims Operations. Both the Claims Manager and Supervisors present at these trainings six times a year. Weekly the Claims Manager meets with the CEO/COO in the Provider Relations, Reporting and Claims meetings (PRRC).	*(See attached file: 3.5.1 Claims Training and Quality Enhancements.docx)*		CCHP out of the process (slide 7). **04/23/18** – The following documentation supports the MCP's efforts to correct this finding: - An email (04/23/18) from the plan which explains the new electronic process. The plans goal is to find a technological solution like a 237 where these claims would be routed between the clearing houses and not require a manual intervention (CCHP is Docustream and Kaiser - Health Relay). The plan's IT Department is in discussions with Kaiser. They would set up a 237 Process so that the clearing houses - DocuStream (CCHP's Clearing House) and Kaiser's Clearing House (Health Relay) can coordinate. This electronic process will avoid a tedious manual process of DocuStream sending the plan batches of Claims then have the plan's Claims Staff touch them a second time and send to Kaiser. In the interim the plan is maintaining

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	Next we did a review of our Claims Auditing System and improved the process by adding an Automated Auditing System for all hospital contracted to ensure the claims were paying in accordance with the Claim Rules which provided another learning opportunity for the Claims team. In addition, the Claims Manager now meets quarterly with other Local Health Plans in California and bring back the experiences of other plans to enhance the training of her team. We have worked collaboratively with other plans on their Audits & Training's of their teams. Therefore, our Claims Department now has scheduled quarterly training and ad hoc trainings as new policies are created and many opportunities to look at our operations and get ideas from our team. With all the trainings in 2017 we have established time frames			the manual process until this system is up and running. **04/24/18** – The following documentation supports the MCP's efforts to correct this finding: - OSR Meeting Minutes (01/10/18) which provides evidence that the plan in the process of implementing a new system to forward misdirected claims to the appropriate capitated provider within 10 working days. The manual process will convert into an electronic process set-up for 277 electronic rejections. The plan will meet with Kaiser Project Managers to propose a solid solution regarding this electronic process set-up for 277 electronic rejects. - OSR Meeting Minutes (04/04/18) which provides evidence that the plan is in the process of implementing a new system to forward misdirected claims to the appropriate capitated provider within 10 working days. The plan is working with Kaiser to change their process and stop sending paper

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	for trainings as new staff join the team and on-going training to ensure quality and learning is part of the Claims Department culture.			claims. The plan's IT department will send a request to Kaiser to use an 837 format to submit claims and not have the Health Plan. The plan is also working on where to send the paper claims until the new electronic solution is implemented. **This finding is closed.**
5. Quality Management				
5.1.1: Implement real-time system to rapidly identify new or changed adult preventive services guidelines so that they can be immediately approved and integrated into the Plan's preventive medicine system.	1. Tracked source of deficiency 2. Updated guideline to include all required recommendations 3. Signed up to receive instant updates when new recommendations are posted 4. Updated policy to require the preventive guidelines is updated immediately upon addition of new A&B recommendations by USPSTF. **04/25/18 Updated Response:** Contra Costa Health Plan formerly had a process of updating preventive guidelines every two years, unless there	Preventive Guidelines Policy QM14.603	12/1/2017	**04/06/18** – The following documentation supports the MCP's efforts to correct this finding: -Revised P&P, "QM14.603: Clinical Practice and Preventive Health Guidelines" (12/01/17) which demonstrates that MCP's Quality Council reviews and approves guidelines every two years and revise if necessary. If new standard are published before the two year review period, the guidelines will be reviewed by the Plan Medical Consultant who will make determination regarding the timing of the revision.

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	was a significant change. When we discovered that new recommendations had been left out, we decided to tighten up our process. We changed our policy and practice, and now we update the guidelines as soon as a new A or B recommendation is added. The USPSTF website facilitates this process by offering an email update service that alerts several of our staff who have signed up. These staff receive email notification from USPSTF whenever new recommendations are added or changed. The Quality Director or designee updates the guidelines as soon as the USPSTF informs us of a change. The guidelines are then taken to Clinical Leadership Group for information and for approval. The preventive guidelines are advertised to our members and providers annually and are available on our website.			**04/24/18** – The following additional documentation submitted supports the MCP's efforts to correct this finding: -A copy of updated preventive guideline "Preventive Guideline for Adults – Contra Costa Health Plan and Contra Costa Regional Medical Center" (July of 2017) as evidence that MCP monitors and updates any changes to the clinical preventive services guideline. **04/25/18** – The following additional documentation submitted supports the MCP's efforts to correct this finding: -A written response detailing MCP process of updating preventive services guidelines for adults. (please see MCP's 04/25/18 updated response under Action Taken) **04/24/18** – The following additional documentation submitted supports the MCP's efforts to correct this finding:

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				-A copy of updated preventive guideline "Preventive Guideline for Adults – Contra Costa Health Plan and Contra Costa Regional Medical Center" (May of 2018) as evidence that MCP monitors and updates any changes to the clinical preventive services guideline. **This finding is closed.**
5.3.1: Continue to implement monitoring and oversight of delegated entities through the timely receipt and analysis of quarterly quality improvement reports and other data.	1. negotiated with Kaiser about what reports to forward and to whom 2. Developed form to track reports reviewed each quarter, topics discussed at joint meetings, and topics discussed at the brief call we have added to the beginning of our Benefits Interpretation Meeting. 3. Corrected delegation policy to remove incorrect inclusion of delegation of clinical guidelines to Behavioral Health Department.	New Quality Oversight of Delegates forms. Revised Delegation policy (QM14.301) CCRMC Delegation Audit 2017 Summary	8/1/2017	**04/02/18** - The following documentation supports the MCP's efforts to correct this finding: - "Quality Oversight of Delegates" (Kaiser, Year 2017 and Q1 2018) a tracking system which documents the intake of quarterly reports. It shows review of various reports, such as HEDIS data, Access to Care (non-medical transportation), Out of Network Report, HEDIS data, and Grievance data. - "Delegation Audit of Contra Costa Regional Medical Center and Health Centers 2017 Summary" (November

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				9, 2017). The MCP found the 2017 audit without any major findings. Overall score: • Quality – 88% • Health Education – 83% • Cultural and Linguistic Services -100% • Credentialing – 100% **04/19/18** - MCP submitted following additional documentation to support the MCP's efforts to correct the finding: - Joint Operations Meeting (JOM) Agendas and Meeting Minutes (03/15/17, 05/30/17 & 11/03/17) that demonstrate receipt, review and follow up on various quality improvement reports and other data. - Written response indicating that QM Director is reviewing Kaiser's data. The Plan also has a twice a month call with Kaiser occurring on the second and fourth Monday's of every month in order to increase the oversight of Kaiser. This is in

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				addition to the quarterly JOM with Kaiser. **This is finding is closed.**

Submitted by: **___(Signature on file) _____**
PATRICIA TANQUARY, MSSW, MPH, PH.D

Date: **April 2, 2018**

Title: **CHIEF EXECUTIVE OFFICER**
Contra Costa Health Plan