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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

February 6, 2018

Christine Tomcala, CEO
Santa Clara Family Health Plan
210 E. Hacienda Avenue
Campbell, CA 95008

RE: Department of Health Care Services Medical Audit

Dear Ms. Tomcala:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Santa Clara Family Health Plan, a Managed Care Plan (MCP), from April 3, 2017 through April 14, 2017. The survey covered the period of April 1, 2016 through March 31, 2017.

On February 1, 2018, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on October 18, 2017.

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

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

If you have any questions, feel free to contact me at (916) 552-8946 or Anthony Martinez at (916) 552-8716.

Sincerely,

Jeanette Fong, Chief
Compliance Unit

Enclosures: Attachment A CAP Response Form

cc: Jeff Kilty, 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: Santa Clara Family Health Plan

Audit Type: Medical Audit and State Supported Services **Review Period: 04/01/16 – 03/31/17**

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**
1.1.1 Utilization management program staff Develop policies and processes for LVNs performing UM work that comply with the contract and the	The Plan is currently in discussions with Jeanette Fong and her DHCS colleagues about the LVN scope of license as it pertains to our UM program, and expect to obtain additional clarification regarding this deficiency in the near future.			**12/05/17** – The following documentation supports the MCP's efforts to correct this finding: - Written email (12/05/17) clarifying that the LVN's responsibility in only approving service requests that meet medical necessity criteria. LVNs follow all review protocols for medical

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Business and Professions Code and Board of Licensed Vocational Nursing and Psychiatric Technician's standards.				necessity in accordance with existing policies and procedures which reflect a hierarchy of criteria application including evidence-based guidelines. Any services that do not meet criteria are forwarded to the medical director for final determination considerations. LVNs do not deny services to members. The MCP's written response further described *oversight processes* in place to ensure accurate application of criteria, proper documentation, and timeliness of letter processing by LVNs. The UM Manager or Director of Medical Management (RN) conducts a monthly random review of 10 approved UM authorizations for each nurse. Additionally, IRR is performed twice per year. **01/12/18** – The following additional documentation supports the MCP's efforts to correct this finding: -P&P HS.03: Appropriate Use of Professionals (01/18/17) which reiterates that only a physician, designated behavioral health

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				practitioner or pharmacist may make medical necessity denial decisions. Furthermore, licensed professionals supervise all medical necessity decisions and provide day to day supervision of assigned UM staff. Non-licensed as well as licensed staff (LVNs included) receive training and daily supervision. -P&P HS.09.01: InterRater Reliability (09/19/16) which confirms the MCP's existing practice of performing IRR on all UM staff (including LVNs) to ensure consistent application of medical necessity criteria and guidelines. -"Utilization Management Work Flow: Monthly Quality Assurance" document which confirms the MCP's process of conducting monthly audits of UM files. UM Management pulls at least 5 authorization files each month and assesses the file for various components, one of which includes ensuring adequate clinical documentation (e.g., evidence of clinical review, application of criteria,

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				notification, etc.). -2 sample reviews as evidence MCP is following conducting oversight of LVNs performing UM functions as indicated by its internal P&Ps. One example reflected a case where the LVN approved a service, and another example reflected a case where the LVN forwarded the case to the medical director to review for denial. **This finding is closed.**
1.1.2 Consistency of UM criteria application Implement policies and procedures to ensure the consistency of behavioral health UM decision-making. Include behavioral health in the Plan's inter rater reliability testing.	The Plan's Policy specific to Inter Rater Reliability includes BH decision-making for accuracy and consistency. The Plan's BH team including Medical Directors and consulting Psychiatrist will perform IRR's at the same frequency as the clinical UM staff as well as the Pharmacy staff.	1. Policy HS.09 Inter Rater Reliability	• IRR to evaluate medical necessity decision-making for Behavioral health cases to be completed by 12/15/2017	**01/03/18** – The following documentation supports the MCP's efforts to correct this finding: -Written response (01/03/18) clarifying that IRR testing is completed twice per year. The plan reported that it has completed testing for BH staff and will present the report to the UMC on 01/17/18. - "InterRater Reliability Summary 2017" (01/03/18) as evidence that the plan has conducted IRR testing for BH specifically on 12/08/17.

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				This finding is closed.
1.2.1 Prior authorization exclusions Revise and implement policy and procedures to ensure preventive services such as screening colonoscopies are not subject to prior authorization.	In accordance with USPSTF guidelines, the Plan modified their 2018 Prior Authorization grids to exclude the requirement for a prior authorization for all preventative screenings including colonoscopies. Additionally, the Plan updated the provider manual Section 10 – Authorizations to include colon cancer screening as a direct access benefit and information about covered services.	1. UM Committee meeting minutes dated 10/26/2017 2. Approved CMC PA Grid 2018 3. Approved Medi-Cal PA Grid 2018	• New provider manual to be complete by 12/1/17 • 2018 Prior Authorization grids become effective 1/1/2018 and eliminate PA requirements for preventative screenings	**11/17/17** - The following documentation supports the MCP's efforts to correct this finding: - UM Committee minutes (10/26/17) serve as evidence that the UM Committee reviewed the Med-Cal Prior Authorization grid to remove all preventive services (including colonoscopies) as requiring prior authorization. Grid will be forwarded for publication to the website and providers will be notified via the web for a 01/01/18 go live date. **11/21/17** - The following additional documentation supports the MCP's efforts to correct this finding: - Prior Authorization Grid for Medi-Cal and Healthy Kids (2018) confirms the removal of colonoscopy as a procedure that requires prior authorization. **This finding is closed.**

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1.2.2 Notice of action (NOA) letters Implement policy and procedures to ensure clear and concise notice of action letters that contain specific and accurate denial information.	The Health Services department developed a specific verbiage matrix including the most commonly used services resulting in a denial, or modification of an authorization request which will result in consistently clear and concise explanations for the reasons for such decisions. Additionally, the Pharmacy Department revised its procedure titled PH.03.01 Medi-Cal HK Prior Authorization to exclude medical jargon and technical language for member letters. Attached is our denial language template used during the audit period and revised denial language.	1. NOA Denial verbiage template 2. PH.03.01 Medi-Cal HK Prior Authorizations 3. Pharmacy Denial Language Matrix	• 11/15/2017	**11/16/17** – The following documentation supports the MCP's efforts to correct this finding: - Updated "Denial/NOA Letter Language Matrix," (undated) as evidence that the plan is using a template for writing complete and understandable reasons for the denial letters. This matrix addresses the most common denial reasons. DHCS provided technical assistance to the plan indicating that the finding for medical PAs also had to do with letters citing inaccurate rationales that were inconsistent with the health record. Plan was asked to address this component of the finding. - Updated pharmacy policy, "Policy Number: PH.03.01, Prior Authorization (PA) Process" (11/13/17) which requires denied pharmacy prior authorization notifications to include a clear and concise explanation of the reasons of the plan's decision, without medical jargon and technical language (Section II.F.v, page 2).

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				- Updated "Pharmacy Denial Language Matrix" (11/16/17) which documents the plan's efforts to revise standardized denial language to make it more clear and concise to the member. DHCS provided technical assistance to the plan indicating that the finding for pharmacy also had to do with the use of canned language for denials rather than member-specific information. Plan was asked to address this component of the finding. **01/08/18** – The following additional documentation supports the MCP's efforts to correct this finding: - Updated pharmacy policy, "Policy Number: PH.03.01, Prior Authorization (PA) Process" (01/08/18) which has been further enhanced to require the plan to include member specific language in addition to a clear and concise rationale without medical jargon and technical language. P&P additionally outlines monitoring processes to

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				ensure adherence to the policy. Policy indicates that a monthly sample of denied PA requests will be reviewed for appropriate denial language including inaccurate rationales. - Updated health services policy," Policy Number: HS.04, Denial of Services Notification" (01/08/18) which like the corresponding pharmacy policy, similarly requires denial notices to include the rationale for the plan's decision without medical jargon and technical language, as well as requiring the letter to be easily understandable for a layperson with member specific language. - Updated "Quarterly Quality Monitoring UM HS04.01 Template" (01/08/18) as evidence that on the medical side (not pharmacy) the plan conducts quarterly plan quality reviews of NOA letters. MCP has added columns Q & R to require the reviewer to assess the following elements:

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				• Letter quality: readability and clinical reason for denial • Is rationale accurate and member specific? **This finding is closed.**
1.2.3 Prior authorization timeframes for behavioral health treatment Revise and implement policy and procedures that require contractually compliant timeframes for processing BHT prior authorizations.	The Plan confirmed that the Plan's existing procedure specific to prior authorization processing and reviews reflects contractually compliant timeframes for processing BHT authorizations.	1. Procedure HS 01.01 Prior Authorization	• 11/15/2017	**12/19/17 –** The following documentation submitted supports the MCP's efforts to correct this finding: - "BHT Referrals" spreadsheet (authorization requests spanning from July 2017 through November of 2017) as evidence that MCP has a process for monitoring the timeliness of BHT prior authorization requests. The log shows 26 PA requests that were received and tracks the timeliness of authorizations. -An email response explaining that in addition to the sample log, MCP has developed an additional UM statistics dashboard. The plan attached an excerpt screenshot (November 2017) which demonstrates MCP separately

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				tracks the timeliness of BH authorizations. Report indicates 53 of 53 BH PA request were processed timely. - Written response documenting the MCPs ongoing and recent efforts to continually expand its BHT network. Efforts include conducting outreach to providers, approving single case agreements, etc. MCP attached a list of BHT providers with five newly contracted providers indicated in red. **The finding is closed.**
1.2.4 Sexually transmitted disease (STD) treatment Revise the member EOC to indicate that enrollees may obtain follow-up STD care in out-of-network local health departments and	The Plan is currently in the process of creating a new EOC utilizing the DHCS Model Handbook, which indicates that members can seek care from out-of-network providers without an authorization for treatment of STDs.		• Q1 2018	**11/16/17 –** The following documentation supports the MCP's efforts to correct this finding: -Excerpt from the 2018 EOC (pages 21-22) as evidence that MPC is using approved language from the DHCS Model Handbook. While the DHCS template language does not specifically indicate that *follow-up* care can be obtained from out-of-network providers, there are no restrictions indicating that they

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family planning clinics.				cannot be. The section on Sensitive Care (Minor Consent Services and Adult Sensitive Services) clearly indicates that members may obtain services for sexually transmitted infections from out-of-network providers and no PCP referral is needed. **This finding is closed.**
1.3.1 Referral tracking Develop and implement a system to track all approved Pas to completion in an ongoing and year round process; include behavioral health Pas and those for contracted and non-contracted providers.	The Plan completed development of new Procedure specific to Referral Tracking processes.	1. Procedure HS 01.02 Referral Tracking	• 11/06/2017	**12/08/17 –** The following documentation supports the MCP's efforts to correct this finding: -Revised P&P "HS.01.02: Referral Tracking System" (11/06/17) which revises the MCPs processes to track *all* prior authorizations (1. contracted and non-contracted 2. BH and non-BH) to *completion*. On a monthly basis, all authorizations will be matched to see if there is a corresponding claim. • For authorizations for which there is a matching claim, the date of service will be noted to examine the timeliness of the

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				referral completion. A quarterly analysis will be provided to the UMC. • For authorizations for which there is no matching claim, a sampling of 10% or up to 50 outpatient specialty authorizations will be examined to assess potential barriers for the delay in care. The review will be presented to the UMC annually. -Written response (email 12/08/17) clarifying that the MCP's QNXT claims processing system has the capability of performing a monthly sweep that captures all types of authorization (e.g., medical, BH, LTSS, LTC, OON, in-network, etc.). -Written response (email 12/08/17) affirming that moving forward, the MCP will capture the date of service from the claim to examine the timeliness of completion for those PA referrals that were approved. The MCP submitted a sample

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				configuration of how this report might look like. MCQMD confirmed the following critical elements were present in the sample report: • Date auth was provided • Claim match (Y or N) • Services date of claim • Delta: diff between date of auth provided and date of service. **This finding is closed.**
1.3.2 Referral tracking and providers Revise Plan informing materials for providers to ensure providers are aware of the prior authorization tracking process.	Communication processes and notifications are to be developed for individual providers to reflect Pre-Service Authorization data compared with Encounter data to determine gross number of unused authorizations. Additionally, the Plan is currently developing a new provider Authorization portal which will help to streamline this process for greater efficiency. Furthermore, the		• New provider manual and website updates to be complete by 12/1/17 • The new communication processes and notifications	**12/22/17 –** The following documentation supports the MCP's efforts to correct this finding: -Written email response (12/22/17) which indicates draft revisions made to the Providers Manual to include detailed information on the MCP's referral tracking system. Draft language describes the MCP's process of matching paid claims to authorizations, evaluating whether services were rendered timely (reviewing the paid claim date

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	Plan is updating provider manual Section 10 Authorizations – Adding section "How to Track a Prior Authorization Request". Will also review and update information on plan website.		for individual providers will be developed by 12/30/17.	against the authorization date), outbound calls conducted to members who do not complete referrals that were authorized, etc. **This finding is closed.**
1.4.1 Provider appeal letters Revise policy and establish procedures for sending providers acknowledgment and resolution letters when they appeal adverse UM decisions.	The G&A Department revised the Medi-Cal appeals procedure to indicate that the Plan sends notification based on the requestor. Specifically, if the provider files the appeal, notification will be sent to both the member and the provider. Please see Medi-Cal appeals policy GA.08 and appeals procedure GA.08.01. Section II(h)(vi) "Determinations" reflects the appropriate updates to our notification process.	1. GA.08 Medi-Cal Appeals Policy 2. GA.08.01 Medi-Cal Appeals Procedure	• Revised Policy and Procedure became effective on 7/3/17.	**11/16/17** – The following documentation supports the MCP's efforts to correct this finding: - Updated policy, "Policy Number: GA.08.01, Medi-Cal Appeals" (07/03/17) which clarifies that if the provider files an appeal on behalf of a member, written notification will be sent to the provider and member (Section II.h.vi, page 4). (01/22/18 email response from MCP confirms that "notification" refers to "written notification.") **12/22/17** – The following documentation supports the MCP's efforts to correct this finding: -Written response (12/22/17) affirming that in July/August 2017, the G&A Department received

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				training and reviewed the changes made to the revised P&P. MCP additionally confirmed that the G&A Manager or designee reviews all letters prior to the appeal closing to ensure that letters go out to the right person (i.e., the provider receives all notices if he/she files the appeal on behalf of the member). DHCS provided technical assistance to the MCP to inquire whether *acknowledgment* letters receive the same type of review as *resolution* letters since the G&A Manager's review doesn't occur until resolution of the case (and after the acknowledgement letter is already sent). **01/22/17** – The following documentation supports the MCP's efforts to correct this finding: - Written response (01/22/18) clarifying that although acknowledgement letters are not reviewed upon mailing, when cases come in, they are reviewed during the MCP's G&A standup. For each case,

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				the G&A staff presents the following information: • Standard or Expedited • Grievance, appeal or State Hearing; • ***Requestor: provider, member, authorized representative.*** MCP indicates this helps the G&A staff to identify and confirm who the requestor is. Cases are presented prior to the acknowledgement letter being mailed. **This finding is closed.**
1.4.2 Appeal letter rationale Develop and implement procedures to ensure appeal resolution letters include a clear and accurate rational for the Plan's decisions.	The G&A Department implemented a process in March 2017 to ensure that notices are written an in easy to understand and accurate format. The G&A Operations Manager works with the Medical Director and Chief Medical Officer to make clinical appeals easy to understand for our members.	1. Quality Monitoring Log	• March 2017	**01/03/17** – The following documentation supports the MCP's efforts to correct this finding: - Grievance & Appeals Quality Monitoring Tool (11/16/17) which describes the MCP's process for reviewing G&A resolution letters. The process requires the G&A Operations Manager to ensure the resolution letter includes the decision-maker's

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				rationale in a clear and easy to understand format. Medical jargon must be understandable to a layperson. **01/19/17** – The following documentation supports the MCP's efforts to correct this finding: -MCP's written response (01/19/18) confirms that MCP has corrected language to ensure that for overturned denials, decision makers ensure the reason for the approval is clearly identified. If the overturned decision was based on additional information, the MCP indicates what part of the additional information allowed for the approval of the service. The MCP has educated decision makers and administrative staff. **02/01/17** – The following documentation supports the MCP's efforts to correct this finding: -Desktop Procedure GA 11.01 "Grievance and Appeal Resolution

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				Letter Monitoring" that indicates that the plan is performing quality monitoring of appeal notices. The SCFHP Medical Director will review at least 30 appeal notices per quarter to analyze the decision and rationale of the appeal including appropriate documentation. **This finding is closed.**
2.4.1 Preventive services for adult members Develop and implement policies and procedures that support compliance with the requirement to provide preventive health services including USPSTF "A" and "B" recommended services.	The Plan created a procedure around the review of USPSTF A and B recommended services. Guidelines are also posted and maintained on the SCFHP website. The guidelines were first posted on April 10, 2017. Guidelines will be updated on an ongoing basis and updates will be communicated through provider newsletters and other mechanisms such as fax blasts. Internal plan staff will be trained as described in procedure QI 10 04. Additionally, the Plan is updating provider manual	1. QI.10.04 IHA Provider Notification Procedure 2. USPSTF A and B Guidelines on website	• Guidelines were posted on 4/10/17. • QI.10.04 IHA Provider Notification Procedure will be implemented 12/1/17 • New provider manual and website updates will be	**11/17/17** - The following documentation supports the MCP's efforts to correct this finding: - Procedure QI.10.04: Clinical Practice Guideline Use for IHA (11/06/17) was developed to inform providers of SCFHP and DHCS's requirement to use the most current version of USPSTF A&B recommended preventive health services to improve member health. The Policy states that the MCP will provide training and will update the MCP's website with new guidelines. - MCP's IHA Website screen shot which provides providers with a direct

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	Section 21 - Medical Record Standards for the Provider Office/Clinic. This section will be updated to incorporate all USPSTF A & B recommended services. Section 4 -Role of Primary Care Provider will also be updated to include a reference to this section.		complete by 12/1/17 • Staff training will be completed in December 2018	link to the most recent USPSTF A&B guidelines. **12/04/17** - The following additional documentation supports the MCP's efforts to correct this finding: - The Provider Manual was updated to educate providers they must provide preventive services, including USPSTF "A" and "B" recommended services. **12/22/17** - The following additional documentation supports the MCP's efforts to correct this finding: - A narrative, "SCFHP Oversight of Provider Adherence to USPSTF Guidelines" submitted by the MCP details all oversight methods the MCP uses to ensure Providers provide USPSTF "A" and "B" recommended services during the provision of IHAs: • In addition to regular Facility Site Reviews (FSR), the MCP also conducts interim surveys

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				of providers in between FSR cycles which includes an abbreviated medical record review. • The MCP also requires providers to annually attest to compliance with USPSTF A and B guidelines utilizing the SCFHP provider portal. Reports are produced and providers who have not attested are sent reminders. • IHA compliance is audited quarterly by a Quality Improvement Nurse who reviews medical records from randomly selected providers with members who should have had an IHA during the previous 120 days. • IHA compliance data is discussed at QI meetings. **This finding is closed.**

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2.5.1 Provision of complex case management to eligible members Implement procedures to ensure participation of PCPs in the provision of CCM services to eligible members.	Case Management currently has procedure in place to provide PCPs the opportunity to review and participate in the development of the Individualized Care Plan (ICP) for the member. Case Management worked with Provider Network Management to update the Provider Manual to include language that describes the role of the PCP in the provision of CCM services, specifically the PCP role in development of the Individualized Care Plan (ICP).	1. Letter template: 80018E Provider – ICP Customized (Cover Letter plus Care Plan)	• The new letter template was implemented on 7/1/17 • New provider manual and website updates will be complete by 12/1/17	**12/04/17** - The following documentation supports the MCP's efforts to correct this finding: - The Provider Manual's Case Management section (Section 11) was updated (12/04/17) to require the Case Manager to contact the PCP's office periodically to maintain close communication to ensure the member's treatment plan, referrals, and educational plans are carried out. **12/08/18** – Technical assistance was provided to the plan to emphasize that the PCP's input and feedback should be elicited in *development* of the ICP. **01/11/18** - The following additional documentation supports the MCP's efforts to correct this finding: -Revised template letter generated from the MCP's case management system which informs providers of a member's desire to participate Case Management Program. The letter

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				provides the provider with a copy of the ICP that has been developed by the case manager, but now also includes an additional statement indicating that the plan would like to work with the provider to customize the plan to address the member's specific needs. - MCP's written response (email 01/11/18) indicating its Case Management and Marketing teams are currently addressing the need for revisions to this template to include more specificity on how PCP's will be able to make changes to the ICP and contact the Case Manager. Anticipated revisions are expected to be completed during Q1 2018. **DHCS will continue to monitor full implementation of this CAP in the subsequent audit.** **This finding is closed.**

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3.5.1 Emergency room service and family planning claims for possible CCS members Develop and implement a process to properly adjudicate ER and FB claims for potential CCS members.	The Plan implemented a new claims processing system (QNXT). QNXT does not apply CCS denials to claims. All claims are now matched to approved CCS cases and/or are reviewed by our CCS nurse.		• Claims processing system was implemented 7/1/17	**12/21/17 –** MCP submitted the following documentation to support its efforts to correct this finding: - The MCP's Claims Director provided a written response clarifying that all CCS claims are paid initially outright and no claims are denied. On the backend, if there is a matching approved CCS case, MCP seeks to obtain reimbursement for any overpayments. MCPs written response stated: "To correct our inappropriate denials, we have configured our new system to pay claims without denials for any CCS covered services. The system cannot be directly "connected" to the CCS data and we cannot manually review all claims prepayment for possible CCS eligibility. The exception to this is that claims with a payment amount over $10,000 are reviewed by an RN, including verification of approved CCS cases or cases that need to be sent to CCS for initiation.

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				A process to perform retrospective audits is being developed that will identify claims that match CCS approved cases and potential cases based on suspected diagnosis and/or CPT codes. If paid claims are identified as eligible for an approved CCS case, we will perform adjustments and request refunds of overpayments." **This finding is closed.**
3.5.2 Prior authorizations for emergency room service claims Develop and implement a process to ensure ER claims are not subject to PA by the Plan.	The Plan implemented a new claims processing system (QNXT). QNXT is configured without authorization requirements for ER service providers. This was tested and is working properly.		• Claims processing system was implemented 7/1/17	**12/07/17** – MCP submitted the following documentation to support its efforts to correct this finding: - Samples of two claims that have tested in the new QNXT system. MCP submitted sample screen shots as the evidence that the new claims processing system has been reconfigured to not require UM authorization for claims payment. - Written communication indicating that subsequent to the initial conversion testing, the Claims

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				Department is conducting monthly audits using a sample pull similar to that provided to DHCS as part of the pre-audit sample request. The Claims Director is reviewing the pull to ensure that no cases are being denied for prior authorization. DHCS requested a recent example of a monthly audit to verify full implementation. **01/12/18 –** MCP submitted the following additional documentation to support its efforts to correct this finding: - MCP submitted a recent monthly audit report, "ER" (payments dated 11/03/17 - 11/28/17), as evidence MCP has fully implemented its monitoring system. MCP's written response affirms that the report is used to identify any incorrect denials that would prompt the MCP to make updates to the system configuration and/or re-train staff. For any claims that are identified as processed incorrectly, adjustments are subsequently made.

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				This finding is closed.
3.5.3 Emergency room service claims for non-contracted providers Develop and implement a process to ensure ER claims submitted by non-contracting providers are appropriately adjudicated.	The Plan implemented a new claims processing system (QNXT). QNXT is configured without authorization requirements for ER service providers. This was tested and is working properly.		• Claims processing system was implemented 7/1/17	**12/07/17** – MCP submitted the following documentation to support its efforts to correct this finding: - A sample of one ER claim for non-contracted provider that has been tested in the new QNXT system. MCP submitted the sample screen shot as the evidence that the new claims processing system has been reconfigured to not require UM authorization for ER claims payment for non-contracted providers. -Written communication indicating that subsequent to the initial conversion testing, the Claims Department is conducting monthly audits using a sample pull. The Claims Director is reviewing the pull to ensure that no cases are being denied for prior authorization. DHCS requested a recent example of a monthly audit to verify full

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				implementation. **01/12/18 –** MCP submitted the following additional documentation to support its efforts to correct this finding: - MCP submitted a recent monthly audit report, "ER" (payments dated 11/03/17 - 11/28/17), as evidence MCP has fully implemented its monitoring system. MCPs written response affirms that the report is used to identify any incorrect denials that would prompt the MCP to make updates to the system configuration and/or re-train staff. For any claims that are identified as processed incorrectly, adjustments are subsequently made. **This finding is closed.**
3.6.1 Monitoring the provision of drugs prescribed in emergency circumstances Revise and	The Plan's Pharmacy Department has revised our procedure titled PH.05.02 ER Supply Access Monitoring to include sampling of cases without prescription claims	1. PH.05.02 ER Supply Access Monitoring	• 1/31/18	**12/05/17** – The following documentation submitted supports the MCP's efforts to correct this deficiency: -Updated P&P, "PH.05.02:

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implement policies and procedures to take actions when deficiencies in the provision of drugs prescribed in emergency circumstances are identified.	history following an emergency room visit to identify insufficient supply, non-dispensing, and barriers to care. Cases that are identified for deficiencies will be sent to Quality Improvement for further investigation. Updated report analysis in process.			Emergency Supply Access Monitoring" (revised 11/21/17) which describes the plan's overall process for evaluating access to prescription meds following an ER visit. On a quarterly basis, a report will be generated which address both: 1) ER visits where there is no claims history (to identify non-pharmacy point-of-sale in-hospital dispensing or completion of in-house drug regimen) 2) ER visits for which there is a matching claim (to assess whether a sufficient quantity was prescribed). (Section II.E. ii and iii) **12/22/17** – The following documentation submitted supports the MCP's efforts to correct this deficiency: -Written response confirming that MCP has developed set milestones for full implementation of its revised reporting process. • Q3 2017 data collection will commence the first week of

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				January 2018 with an anticipated draft report to be completed by February 2018. • Q4 2017 data collected will commence in March 2018. • Q1 2018 data collection will be delayed until May 2018 to account for the claims processing lag. **This finding is closed.**
4.1.1 Quality of Care (QOC) grievances Ensure that a health care professional with clinical expertise in treating a member's condition or disease resolves grievances that involve clinical issues.	All QOC grievances are reviewed and investigated by a health care professional with clinical expertise. The QI Nurse reviews all grievances and investigates the QOC issues, all grievances not meeting criteria are also presented to the Medical Director as an additional layer of review.	1. QI.05.05 Quality of Care Review Oversight Procedure		**11/17/17** – The following documentation supports the MCP's efforts to correct this deficiency: -Updated P&P, "QI: 05.05 Quality of Care Review Oversight" which will ensure all medical quality of care (QOC) issues are referred to the MCP Medical Director via the following: • All medical QOC issues are reviewed by QI Nurses • All QOC issues identified will be investigated by QI nurse and presented to Medical Director • All other grievances not

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
				identified as QOC will be presented to MCP Medical Director for inter-rater reliability on an ongoing basis DHCS requested clarification from the plan on the frequency of the IRR process and whether the Medical Director was reviewing all grievances not identified as QOC or a sample of cases. **12/21/17** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: -A written email (12/21/17) which provides clarification on oversight and review to be done by the Medical Director. QOC review oversight will include the following: • On a semi-annual basis, QI Department will request all grievances that did not meet QOC criteria for previous six months. First run will be February 2018 and look back

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				10/1/17 – 1/31/18. • QI Department will pull random sample of 30 cases not flagged for PQI. • MCP Medical Director will perform IRR. • Findings to be shared with QI Nurses and incorporated into identification of QOC issue process. -Previously updated P&P, "QI: 05.05 Quality of Care Review Oversight" which will ensure all medical quality of care (QOC) issues are referred to the MCP Medical Director has been enhanced to clarify that a random sampling of 30 grievances not identified as QOC to be selected for IRR and feedback incorporated into Potential Quality of Care issue process. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
4.1.2 Exempt grievances Consistently implement the procedure to ensure exempt grievances are fully resolved prior to closing a case within 24 hours. Implement a process to monitor the classification of standard and exempt grievances.	The Customer Service Grievance intake workflow was revised to clearly indicate the timeframe for resolving exempt grievances. In addition, the Customer Service Department developed the Customer Service Exempt Grievance Desktop Guidelines to monitor the daily process for ensuring all standard and exempt grievances are classified accurately and consistently and are resolved to the satisfaction of the member or complainant.	1. Grievance Work Flow in Customer Service 2. Customer Service Exempt Grievance Desktop Guidelines 3. Intake of Grievances and Appeals Procedure	• September 2017	**11/17/17** – The following documentation supports the MCP's efforts to correct this deficiency: -Updated Grievance Work Flow (09/26/17) has been revised to reflect exempt grievances must resolved by close of next business day. -Updated desktop procedure (10/30/17) that accurately defines an exempt grievance. Desktop procedure commits the plan to running a Daily Call Tracking report on all open and closed exempt grievances to ensure all exempt grievances have been properly categorized and resolved to the satisfaction of the member. -Updated P&P, "CS.12.01 – Customer Service Intake of Grievances & Appeals" (06/13/17) which has been amended to include a section on standards for categorizing and routing member grievances (4.iii) and a section on monitoring and reporting on a daily basis, the timeliness of resolution of

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
				grievances, including an exempt log that will be regularly reviewed for quality assurance. **11/30/17** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: -Copies of recent daily call tracking reports (11/20, 11/21, 11/22, 11/27) as evidence MCP is implementing its new daily monitoring procedure to ensure proper categorization of exempt grievances. -"Daily Checklist for Grievances Resolved in Customer Service" which includes a description of the MCP's daily process for running the tracking reports and ensuring all cases have been properly categorized. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
4.1.3 Grievances on behalf of a member Implement the policy to send all complainants the required written acknowledgement and responses to the grievances.	The G&A Department revised the Medi-Cal grievance procedure to indicate that the Plan sends notification based on the requestor. Specifically, if a member's authorized representative files the grievance, notification will be sent to the member's authorized representative. Please see Medi-Cal grievances policy GA.03 and grievances procedure GA.03.01. Section II(i)(iv) "Resolving Grievances" which reflects the appropriate updates to our notification process.	1. GA.03 Medi-Cal Grievance Policy 2. GA.03.01 Medi-Cal Grievance Procedure	• Both the Policy and Procedure were implemented in July 2017	**11/17/17** – The following documentation supports the MCP's efforts to correct this deficiency: -Updated P&P, "GA.03: Medi-Cal Grievances" (07/03/17) which outlines the MCP's overall grievance process, including timely notification to the member or authorized representative (Section II.c.ii.2, page 2). -Updated P&P, "GA.03.01 Medi-Cal Grievances outlines overall procedures, including the name of member or requestor and who the requestor is (provider, member, member representative). (Section II.c, page 2). Requires G&A Coordinator to ensure Authorized Representative Form or equivalent document is on file and outlines procedures for addressing authorized representatives. **01/02/18** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency:

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
				-A written email (12/15/17) which provides clarification on oversight and monitoring efforts to ensure written notices are being sent to the appropriate complainant and/or appellant. The MCP submitted the following three Standard Operating Procedures as evidence: • Grievance & Appeals Resolution Letter Review which includes ensuring correct person (member, provider, authorized or unauthorized representative) is being sent the notice. • Grievance & Appeals Intake Process which includes identifying who is filing the grievance and/or appeal and ensuring notices are being sent to the appropriate party in accordance with the P&Ps. • Grievance & Appeals Stand Up: Standard Operating Procedure which indicates

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				G&A Department meets weekly to discuss open grievance and appeal cases and determine who each request was filed by (member, provider, authorized or unauthorized representative). The plan also attached an email to substantiate that staff have attested that they have acknowledged and understood the attached SOP. **This finding is closed.**
4.1.4 Grievances training material Revise training materials provided to staff to be consistent with contractual requirements.	DHCS identified an error in the previous training material regarding the timeframe to file an appeal and/or grievance. Since our 2017 DHCS audit, DHCS released a new All Plan Letter (APL) on the Grievance & Appeals System. APL 17-006 updated the timeframes requirements for both grievances and appeals. The Plan has since developed training that explains the changes to the grievance and	1. Grievance & Appeals training material	• Training is underway and is expected to be completed with all member facing departments by the end of December 2017	**11/17/17** – The following documentation supports the MCP's efforts to correct this deficiency: -PowerPoint training, "Medi-Cal Appeals and Grievances Annual Training." The training materials were found to be very thorough and comprehensive and have been revised to be consistent with updated G&A timeframes pursuant to APL 17-006. Timeframes for grievance filing (any time) and appeal filing (60 calendar days) are clearly delineated.

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	appeals process. Specifically, there is no longer a filing timeframe for grievances, and there is now a 60 calendar day timeframe for filing an appeal. The G&A Department utilized the resources provided by DHCS to develop the training.			-DHCS provided minor technical assistance on 11/17/17 advising MCP to revise language in training to ensure that exempt grievances are resolved by the close of the next business day (not 24 hours) for consistency with the regulatory requirement. **11/30/17** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: -Revised Power Point training, "Medi-Cal Appeals and Grievances Annual Training" to reflect contractual requirement for resolution timeframe regarding exempt grievances by the following business day. -All Staff Meeting agenda (11/16/17) which provides evidence Grievances and Appeals training was conducted in two sessions (first session on 11/16/17; second session on 01/18/18).

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
				This finding is closed.
4.3.1 Notification of unauthorized disclosure of protected health information Implement the policies and procedures to ensure privacy breaches and security incidents are reported to DHCS within 24 hours.	The Plan's Compliance Department is responsible for notifying DHCS of any privacy breaches and security incidents within 24 hours. During the audit period, the Compliance Department experienced a severe staffing shortage as 2 of 3 the department members at that time were out on leave during overlapping periods. This resulted in only one person managing all functions of the Compliance Department, including the reporting of privacy breaches and security incidents to DHCS. Beginning in March 2017, the Compliance Department underwent a significant staffing increase and organizational restructuring. These changes have allowed the Department to cross-train several individuals to ensure		• March 2017	**11/30/17 –** The following documentation supports the MCP's efforts to correct this finding: -Desktop procedure, "HIPPA Incident Desk Reference," that serves as evidence that the Compliance Department staff receive guidance on how to report security breach incidences to DHCS timely at all three reporting timeframe junctions (i.e., 24hrs, 72hrs, 10 working days) and to each of the three required DHCS contacts (i.e., Contract Manager, Privacy Officer, Information Security Officer). **12/19/17 –** The following additional documentation submitted supports the MCP's efforts to correct this finding: -"2017 SCFHP Breach Tracking Log" which contains 17 security breach

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
	that the Plan has adequate staffing to complete the reporting within the contractual timeframes.			cases reported to DHCS for period of January 2017 through November 2017. The log shows all the cases were processed and reported to all 3 DHCS entities timely with the exception of 4 cases for which the MCP has provided an explanation. Nevertheless, the log demonstrates the MCP has oversight mechanisms in place to detect and correct reporting issues. **12/22/17 –** The following additional documentation submitted supports the MCP's efforts to correct this finding: -Blank revised SCFHP Breach Tracking Log as evidence MCP has made improvements to column headers to more accurately capture the discovery of the breach. The enhanced tracker will be used beginning in 2018. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
4.3.2 Submission of suspected protected health information breach investigations Implement the policies and procedures to ensure reports of suspected security incidents investigations are submitted to DHCS within 72 hours.	The Plan's Compliance Department is responsible for providing DHCS with reports of suspected security incident investigations within 72 hours. During the audit period, the Compliance Department experienced a severe staffing shortage, as 2 of 3 the department members at that time were out on leave during overlapping periods. This resulted in only one person managing all functions of the Compliance Department, including the submitting investigations of security incidents to DHCS. Beginning in March 2017, the Compliance Department underwent a significant staffing increase and organizational restructuring. These changes have allowed the Department to cross-train several individuals to ensure that the Plan has adequate staffing to complete the reporting within the contractual timeframes.			**11/30/17 –** The following documentation supports the MCP's efforts to correct this finding: -"SCFHP Compliance Department Organization Chart" for November of 2017 which shows MCP has added more staff the Compliance Department to ensure security breach incidences are reported to DHCS timely. -Desktop procedure, "HIPPA Incident Desk Reference" as evidence that the Compliance Department staff receive guidance on how to report security breach incidences to DHCS accurately. **12/19/17 –** The following additional documentation submitted supports the MCP's efforts to correct this finding: -"2017 SCFHP Breach Tracking Log" which contains 17 security breach cases reported to DHCS for period of January 2017 through November 2017. The log shows all the cases

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				were processed and reported to all 3 DHCS entities timely with the exception of 4 cases for which the MCP has provided an explanation. Nevertheless, the log demonstrates the MCP has oversight mechanisms in place to detect and correct reporting issues. **12/22/17 –** The following additional documentation submitted supports the MCP's efforts to correct this finding: -Blank revised SCFHP Breach Tracking Log as evidence MCP has made improvements to column headers to more accurately capture the discovery of the breach. The enhanced tracker will be used beginning in 2018. **This finding is closed.**
5.2.1 Provider training on recommended preventive services for	The Plan created a procedure around the review of USPSTF A and B recommended services. Guidelines are also posted and maintained on the		• Guidelines were posted on 4/10/17. • QI.10.04	**11/17/17** - The following documentation supports the MCP's efforts to correct this finding: - Procedure QI.10.04: Clinical

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adults Revise provider orientation materials to include training on Medi-Cal Managed Care program including requirements to provide and document the current edition of USPSTF “A” and “B” recommended services.	SCFHP website. The guidelines were first posted on April 10, 2017. Guidelines will be updated on an ongoing basis and updates will be communicated through provider newsletters and other mechanisms such as fax blasts. Internal plan staff will be trained as described in procedure QI 10 04. Additionally, the Plan is updating provider manual Section 21 - Medical Record Standards for the Provider Office/Clinic. This section will be updated to incorporate all USPSTF A & B recommended services. Section 4 -Role of Primary Care Provider will also be updated to include a reference to this section.		IHA Provider Notification Procedure will be implemented 12/1/17 • New provider manual and website updates will be complete by 12/1/17 • Staff training will be completed in December 2018	Practice Guideline Use for IHA (11/06/17) was developed to inform providers of SCFHP and DHCS’s requirement to use the most current version of USPSTF A&B recommended preventive health services to improve member health. The Policy states that the MCP will provide training and will update the MCP’s website with new guidelines. - MCP’s IHA Website screen shot which provides providers with a direct link to the most recent USPSTF A&B guidelines. **12/04/17** - The following additional documentation supports the MCP’s efforts to correct this finding: - The Provider Manual was updated to educate providers they must provide preventive services, including USPSTF “A” and “B” recommended services. **12/22/17** - The following additional documentation supports the MCP’s efforts to correct this finding:

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
				- A narrative, “SCFHP Oversight of Provider Adherence to USPSTF Guidelines” submitted by the MCP details all oversight methods the MCP uses to ensure Providers provide USPSTF “A” and “B” recommended services during the provision of IHAs: • In addition to regular Facility Site Reviews (FSR), the MCP also conducts interim surveys of providers in between FSR cycles which includes an abbreviated medical record review. • The MCP also requires providers to annually attest to compliance with USPSTF A and B guidelines utilizing the SCFHP provider portal. Reports are produced and providers who have not attested are sent reminders. • IHA compliance is audited quarterly by a Quality Improvement Nurse who reviews medical records from

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
				randomly selected providers with members who should have had an IHA during the previous 120 days. • IHA compliance data is discussed at QI meetings. **This finding is closed.**
6.3.1 Anti-fraud and abuse program implementation Fully implement all policies and procedures to guard against fraud and abuse.	On June 23, 2017, the Plan entered into a Special Investigations Unit Services Agreement with T&M Protection Resources, LLC. T&M has been delegated to manage the day-to-day operations of the SIU consistent with the Plan's FWA Plan, and to perform the specific functions of a SIU, consistent with the Plan's contractual requirements and the rules and regulations of DHCS, DMHC, and other appropriate regulatory agencies.		• 6/23/17	**11/17/17** – The following documentation supports the MCP's efforts to correct this deficiency: -MCP's CAP response indicates MCP has entered into a Special Investigations Unit Service Agreement (06/23/17) with T&M Protection Resources, LLC. T&M has been delegated authority to operate and manage the daily operations of the SIU. DHCS requested documentation to substantiate that the vendor is fulfilling its contractual responsibilities. **12/15/17** – The following additional documentation supports the MCP's

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				efforts to correct this deficiency: -MCP submitted Quarterly Summary Report (12/08/17) outlining SIU activities performed by T&M including, datamining by provider type, CPT Codes, monitoring of OIG and State databases for suspended and ineligible providers, investigations of case referrals by MCP and outside agencies, and monthly pending case reports. **This finding is closed.**
SSS.1 Out of network providers Develop and implement a process to ensure claims submitted by non-contracting providers are appropriately adjudicated	The Plan implemented a new claims processing system (QNXT). QNXT is configured without authorization requirements for sensitive service providers. This was tested and is working properly.		• Claims processing system was implemented 7/1/17	**12/07/17** – MCP submitted the following documentation to support its efforts to correct this finding: - A sample of one sensitive service claim that has been tested in the new QNXT system. MCP submitted the sample screen shot as the evidence that the new claims processing system has been reconfigured to not require UM authorization for claims payment for SSS claims submitted by non-contracted providers. -Written communication indicating

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				that subsequent to the initial conversion testing, the Claims Department is conducting monthly audits using a sample pull similar to that provided to DHCS as part of the pre-audit sample request. The Claims Director is reviewing the pull to ensure that no cases are being denied for prior authorization. DHCS requested a recent example of a monthly audit to verify full implementation. **12/21/17** – MCP submitted the following additional documentation to support its efforts to correct this finding: - MCP submitted a recent monthly audit report, “FP and SSS” (payments dated 11/17/17), as evidence MCP has fully implemented its monitoring system. MCPs written response affirms that the report is used to identify any incorrect denials that would prompt the MCP to make updates to the system configuration and/or re-train staff. For any claims that are identified as processed

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				incorrectly, adjustments are subsequently made. **This finding is closed.**

Submitted by: **Jordan Yamashita** **Date: 11/16/17**
Title: **Compliance Manager**