



JENNIFER KENT  
DIRECTOR

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



EDMUND G. BROWN JR.  
GOVERNOR

Ms. Patricia Tanquary, CEO  
Contra Costa Health Plan  
595 Center Avenue, Suite 100  
Martinez, CA 94553

RE: Department of Health Care Services Medical Audit

Dear Ms. Tanquary:

The Department of Health Care Services (DHCS) Audits and Investigations Division conducted an on-site enrollment survey of Contra Costa Health Plan, a Managed Care Plan (MCP), from March 4, 2013 through March 15, 2013. The audit covered the review period of December 1, 2011, through November 30, 2012.

All remaining open items have been reviewed and found to be in compliance. The CAP is hereby closed. The enclosed report will serve as DHCS's 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, contact Mr. Edgar Monroy, Chief, Compliance Unit, at (916) 449-5233 or [CAPMonitoring@dhcs.ca.gov](mailto:CAPMonitoring@dhcs.ca.gov).

Sincerely,

*Original Signed by Dana Durham*

Dana Durham  
Contract Compliance Section Chief

Enclosure:

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cc: Jonathan Prince, Contract Manager  
Department of Health Care Services  
Managed Care Operation Division  
P.O. Box 997413, MS 4400  
Sacramento, CA 95899-7413

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bcc: Edgar Monroy, Chief  
Compliance Unit  
MS 4417

Hur Khan Allen, Analyst  
Compliance Unit  
MS 4417

**CORRECTIVE ACTION PLAN  
CONTRA COSTA HEALTH PLAN**

REVIEW TYPE: Medical Audit

REVIEW PERIOD: December 1, 2011 through November 30, 2012

Contract Number 04-36067

DEFICIENCIES IDENTIFIED	PLAN OF ACTION	DHCS 1st COMMENTS	CCHP 2 <sup>nd</sup> & 3 <sup>rd</sup> (7/24/14) RESPONSE	DHCS 2 <sup>nd</sup> & 3 <sup>rd</sup> (7/24/14) COMMENTS
<b>1.1.1 RECOMMENDATIONS:</b>				
<p><b>1.1.1-1.</b> Perform trending and analysis of UM data in accordance with the UM Program Description and the Plan's Policies and Procedures.</p>	<p><b>Pharmacy Plan of Action:</b></p> <ol style="list-style-type: none"> <li>1. Pharmacy in process of collaborating with QI to develop under/over utilization monitoring tools. Current plan is to focus on three areas:               <ol style="list-style-type: none"> <li>a. Opioid prescribing</li> <li>b. Asthma medication adherence</li> <li>c. Diabetes medication adherence</li> </ol> </li> <li>2. Future focus could include:               <ol style="list-style-type: none"> <li>a. Hepatitis C</li> <li>b. Multiple sclerosis</li> <li>c. Rheumatoid arthritis</li> <li>d. Pulmonary hypertension</li> <li>e. Data collection of self-monitoring blood glucose test results</li> </ol> </li> </ol> <p><b>Medical Plan of Action:</b> We now have some reports and are getting additional reports to address under/over utilization. The reports are data driven and will monitor and tell us which procedure or tests are done the most and the least, which captures under and over utilization activities.</p>	<p><b>1.1.1-1</b> The MCP must provide supporting documentation demonstrating the implementation of UM data trending and analysis in accordance with the UM Program Description and the Plan's Policies and Procedures. Supporting documentation may include information indicated in the initial CAP response. <b>This finding is open.</b></p>	<p><b>1.1.1-1 Pharmacy CAP response</b> See Opiate Rx Trend Charts and Notes 9_2012 thru 3_2014</p> <p><b>Medical CAP response</b> Refer to documents: 1) UM Workgroup Minutes 3/6/14 2) Healthy Hearts report 3) QC UM Discussion Summary 4/24/14.</p>	<p><b>1.1.1-1</b> The MCP provided a pharmacy trend analysis, meeting and work group minutes demonstrating the use of data trending analyses. <b>This item is closed.</b></p>
<p><b>1.1.1-2a.</b> Implement a data driven mechanism to detect</p>		<p><b>1.1.1-2</b> The MCP must provide</p>	<p><b>1.1.1-2a</b> Controlled_Drug_Utilization</p>	<p><b>1.1.1-2a&amp;b</b> The MCP provided a</p>

<p>over-utilization. <b>1.1.1-2b.</b> Implement a mechanism to detect under-utilization.</p>		<p>supporting documentation demonstrating the use of a data driven mechanism to detect over-utilization. Supporting documentation may include information indicated in the initial CAP response. <b>This finding is open.</b></p>	<p>_Top_members_summary_QL_2014 <b>1.1.1-2b</b> Top_Pharmacy_Utilizers March 2014</p>	<p>Controlled Drug Utilization summary and Top Pharmacy Utilizers list. <b>This item is closed</b></p>
<p><b>1.1.1-3.</b> Use recognized QI tools and techniques to continuously measure and improve its processes.</p>	<p><b>1.1.1-3:</b> Dedicated IT staff has been assigned to the Health Plan to assist in the development necessary UM reports. The below reports will be reviewed and finalized by the UM Workgroup. As appropriated, additional reports will be generated to monitor UM activities. The following reports are now available:</p> <ul style="list-style-type: none"> <li>• Prior Authorization (PA) Turnaround Time for routine and urgent requests</li> <li>• Monthly PA processed</li> <li>• Monthly PA determinations</li> </ul> <p>The following reports are in development with its projected availability timeline noted:</p> <ul style="list-style-type: none"> <li>• Bed days/1000, by product line and bed type, such as med-surg, OB, SNF, etc. (October 2013)</li> <li>• Discharges/1000 (October 2013)</li> <li>• ALOS/admit (October 2013)</li> <li>• Under/over utilization activities, by procedure code and groups (November 2013)</li> <li>• Referral Turnaround Time (October 2013)</li> </ul>	<p><b>1.1.1-3</b> The MCP must demonstrate that it uses recognized QI tools and techniques to continuously measure and improve its process. <b>This finding is open.</b></p>	<p><b>1.1.1-3</b> Refer to document: 1) Sample of Ancillary Services Report 2) These reports are reviewed in UM Workgroup. See example of Workgroup discussions in documents for section 1.1.1-1  Also see Hepatitis C HCV HepC Surveillance  <b>Update 7/24/14</b> 1.1.1-3 CCHP has included a fact sheet further explaining the data that was submitted.</p>	<p><b>1.1.1-3</b> The MCP provided an ancillary services report sample, quality workgroup minutes. In order to close this item, the MCP must provide additional information or fact sheet explaining the data that was submitted and the action the plan has taken in response to the finding. This item remains open.  <b>Update 7/24/14</b> The MCP provided a narrative explanation of the report previously submitted. The information satisfies this deficiency. <b>This item is closed.</b></p>
<p><b>1.1.1-4.</b> Ensure consistency</p>	<p><b>1.1.1-4</b> Following the UM department's Weekly Case</p>	<p><b>1.1.1-4</b></p>	<p><b>1.1.1-4</b></p>	<p><b>1.1.1-4</b></p>

<p>in the application of guidelines by measuring consistency of potentially variable aspects of the UM nurses' work processes and by looking for opportunities for improvement.</p>	<p>Conference, Case Review Challenge (CRC) was implemented in August 2013. The purpose of the CRC is to identify and address areas of strengths and weaknesses in decision-making. Each week following the inpatient case conference, the group, which includes the Medical Director, reviews 1-2 cases for census of determination and consistency of guidelines used.</p>	<p>The MCP must provide documentation that shows it is ensuring consistency in the application of guidelines by measuring the consistency of potentially variable aspects of the UM nurses' work processes and by looking for opportunities to improve those processes. <b>This finding is open.</b></p>	<p><b>Medical CAP response</b> Refer to documents: 1) IRR questionnaire 2) Scores 3) Analysis &amp; Conclusion</p>	<p>The MCP provided a sample of the Inter Reliability survey and respective scores and analyses. <b>This item is closed.</b></p>
<p><b>1.1.1-5</b> Be proactive in its efforts to ensure that all authorized specialty services are rendered in a timely manner and that Members are not subjected to excessive wait times before being seen by a qualified specialty Provider.</p>	<p><b>1.1.1-5</b> The Health Plan will continue to randomly contact specialist and members to determine if the authorized specialty care were rendered. The Plan will decrease the waiting period from 45 to 40 days by December 2013, followed by attempts to incrementally, decrease the waiting period further to eventually meet the 15 business days.</p>	<p><b>1.1.1-5</b> The MCP must provide documentation that shows it is being proactive in its efforts to ensure that its specialty providers render all authorized specialty services in a timely manner and that Members are not subjected to excessive wait times before being seen by a qualified specialty provider. <b>This finding is open.</b></p>	<p><b>1.1.1-5</b> Refer to document: 1) Sample of Referral Tracking grid  <b>Update 7/24/14</b> <b>1.1.1-5</b> CCHP has provided additional information in the fact sheet.</p>	<p><b>1.1.1-5</b> The MCP provided a sample of how they track their specialists. In order to close this item, the MCP must provide additional information or fact sheet explaining the data that was submitted and the action the plan has taken in response to the finding. This item remains open.  <b>Update 7/24/14</b> The MCP provided the additional information requested. <b>This item is closed.</b></p>

<b>1.1.2 RECOMMENDATIONS:</b>				
<b>1.1.2-1.</b> The Plan's policy should clearly state that extensions of time frames for routine authorizations must be in the Member's interest. Members must either request extensions of time frames or Plan must provide justification for the extension.	<b>1.1.2-1</b> See Policy #: UM15.015.a amended to state that extensions of time frames for routine authorizations must be in member's interest. Plan's pharmacy policy rewritten to clearly state that time frame extensions must be in the member's interest.	<b>1.1.2-1</b> The MCP has taken adequate steps to correct the deficiency. This issue was addressed in the P&P. <b>This finding is closed.</b>		
<b>1.1.2-2</b> The Plan's Policy should state a 24-hour time frame for routine Pharmacy PA determinations.	<b>1.1.2-2</b> Plan's pharmacy policy rewritten to state a 24-hour time frame for routine Pharmacy PA determinations	<b>1.1.2-2</b> The MCP has taken adequate steps to correct the deficiency. <b>This finding is closed</b>		
<b>1.1.2-3</b> Adhere to required time frames	<b>1.1.2-3</b> Please see attached 1.1.2 Authorizations Alert TAT and Deferral Notice. a. During the Post Case Conference discussion on 6/26/13, staff was reminded the importance of timely processing of prior authorization requests and that deferral notices can be issued in the Member's interest. b. An email reminder of the above was sent on 9/9/13 to the Auth/UM staff followed by a hardcopy distribution of an Auth Alert bulletin explaining the same. Copy of Auth Alert attached. c. Additional staff was added after onsite audit was completed to reduce excessive TAT.	<b>1.1.2-3</b> The MCP must provide supporting documentation demonstrating that required time frames are being implemented. Documentation provided in finding 1.1.2.4 below may be used in support of this finding as well. <b>This finding is open.</b>	<b>1.1.2-3</b> Refer to document: 1) Auth Decision Tracking log	<b>1.1.2-3</b> The MCP provided an authorization decision tracking log. <b>This item is closed.</b>
<b>1.1.2-4</b> Notify Members and Providers when there is a need to extend time frames for authorizations.	<b>1.1.2-4</b> Please refer to Authorizations Alert TAT and Deferral Notice. Plan's pharmacy policy does state plan will provide written notification to both member and provider when there is a need to extend authorization time frame. Pharmacy PA turnaround statistics addressed under 1.1.3.	<b>1.1.2-4</b> The MCP must provide supporting documentation demonstrating that it notifies members and providers when it needs to extend timeframes for authorizations. Supporting documentation must	<b>1.1.2-4</b> Refer to document: 1) Sample deferral notices Pharmacy PM6.016 has been revised to reflect that only denials will be issued. There are no deferrals beyond the 24 hour or 1 business day TAT.  <b>Update 7/24/14</b>	<b>1.1.2-4</b> The MCP provided a sample of three notification letters and the respective policy and procedure. This item is deemed provisionally approved pending receipt the plan's signed and approved policies and procedure. In order to close this item, please provide approved/signed P&P.

		include a sample of 3 actual notices. <b>This finding is open.</b>	<b>1.1.2-4</b> CCHP has provided a signed and approved policy PM6.016.	This item remains open. <b>Update 7/24/14</b> The MCP provided the approved/signed P&P. <b>This item is closed.</b>
<b>1.1.2-5</b> Produce previously available statistics on turnaround time using the Plan's current software	<b>1.1.2-5</b> The Turnaround Time (TAT) report is now available from ccLink. Report is generated monthly and reviewed no less than quarterly or more frequently with staff and Medical Director "	<b>1.1.2-5</b> The MCP must Provide supporting documentation demonstrating the use of the health plan's current software to produce previously available statistics and health plan action taken based on the results of these statistics. <b>This finding is open.</b>	<b>1.1.2-5</b> See TAT Report in 1.1.3-2. <b>Update 7/24/14</b> <b>1.1.2-5</b> CCHP has provided Quality Council Meeting Minutes from April 24, 2014.	<b>1.1.2-5</b> The MCP provided an Authorization Turnaround Time Statistics report demonstrating quarterly comparisons. In order to close this item, the MCP must provide supporting documentation indicating that actions are being taken based on these results. This item remains open.  <b>Update 7/24/14</b> The MCP provided a copy of minutes from the April 2014 Quality Council Meeting. Narrative citing Authorization Turnaround Time Statistics for 2014 shows marked improvement over 2013. <b>This item is closed.</b>

1.1.3 RECOMMENDATIONS:				
<p><b>1.1.3-1</b> Track procedures and ancillary services.</p>	<p><b>1.1.3-1</b> As noted in CAP submitted for section 1.1.1, there is dedicated IT staff allocated to the Health Plan to assist in developing statistical reports. One of the reports being developed is to track procedure and ancillary referrals. A draft report should be available by November 2013. Pharmacy PA turnaround reporting has been completed and tested. See attachment 1.1.3 for sample output "TAP2572_Pharmacy_PA_Disposition_Summary(1).xls"</p>	<p><b>1.1.3-1</b> The MCP must provide copies of reports used to track procedures, ancillary services, and actions taken based on these reports. <b>This finding is open.</b></p>	<p><b>1.1.3-1</b> 1) Ancillary Services Report 2) TAP2572_Pharmacy_A_Disposition_Summary_April_2014 <b>Update 7/24/14</b> <b>1.1.3-1</b> CCHP has been working with IT to develop a report to track procedures and ancillary referrals. CCHP has attached minutes from June 2014 QC that show CCHP staff including the Authorization Director and Pharmacy Director committing to meeting to discuss reports that are still in development. The MRI was an example of such a report and no action has been taken on this report. However, this ancillary referral report has been scheduled for regular review by our Clinical Leadership Group and QC as necessary. CCHP only requires authorizations for MRIs and Pet Scans. The rest only need a referral from a doctor, not an authorization.</p>	<p><b>1.1.3-1</b> The MCP provided an MRI comparison chart comparing Quarters. In order to close this item; the MCP must provide supporting documentation indicating that actions are being taken based on these results. This item remains open.  <b>Update 7/24/14</b> The MCP submitted a copy of June 2014 Quality Council Meeting minutes and sufficient information to satisfy this deficiency. <b>This item is closed.</b></p>
<p><b>1.1.3-2</b> Monitor process times for PA as was done prior to implementation of the Epic ccLink system.</p>	<p><b>1.1.3-2</b> PA turnaround time (TAT) report is now available. The report is generated monthly and discussed to staff on a quarterly basis to address any deficiencies and/or to streamline processes to improve TAT.</p>	<p><b>1.1.3-2</b> The MCP must provide documentation that demonstrates how it monitored PA process times before it implemented the Epic ccLink system. Supporting documentation may include items mentioned in the initial</p>	<p><b>1.1.3-2</b> Refer to document: 1) Turnaround Time Report. 2) Please also refer to QC Report from 1.1.1 documents for discussion.</p>	<p><b>1.1.3-2</b> The MCP provided an Authorization Turnaround Time Statistics report demonstrating quarterly comparisons. <b>This item is closed.</b></p>

		CAP response. <b>This finding is open.</b>		
<p><b>1.1.3-3</b> Continue to monitor access for authorized specialty visits and continue to address or require action plans until the problem of timely access in multiple specialties at CCRMC is resolved.</p>	<p><b>1.1.3-3</b> The Health Plan will continue to monitor timely access to specialty care visits. CCHP will begin to gradually decrease the wait time limit of 45 to 40 days for specialty care services at CCRMC/HC by December 2013. Thereafter, the Plan will attempt to incrementally decrease the wait time to eventually meet the 15 business day standard. This will allow additional members to be redirected from the CCRMC to the Community Provider Network; reducing the overall wait time for specialty care visits.</p>	<p><b>1.1.3-3</b> The MCP described very good steps toward addressing this finding. The MCP must provide supporting documentation indicating its continued monitoring of access to care for authorized specialist visits and that it is successfully resolving problems of timely access in multiple specialties at CCRMC. <b>This finding is open.</b></p>	<p><b>1.1.3-3</b> Refer to document: 1) Monitoring Access to Specialty Care</p> <p><b>Update 7/24/14</b> <b>1.1.3-3</b> See attached Clinical Leadership Group minutes from 2/13/14 and 4/24/14 QC minutes.</p>	<p><b>1.1.3-3</b> The MCP provided a wait times tracking document. In order to close this finding, the MCP must provide documentation demonstrating the MCP actions taken based on these result. This item remains open.</p> <p><b>Update 7/24/14</b> The MCP submitted minutes Clinical Leadership Group, and Quality Council meetings. Statistics provided at the meetings shows wait times improved by 10 days, and an ongoing commitment for further improvement. <b>This item is closed.</b></p>

1.1.4 RECOMMENDATIONS:				
1.1.4-1 Allow oral or telephonic filing of an appeal and reflect this in the Member Handbook and EOC.	1.1.4-1 The EOC has been revised to: <u>You may send Member Services a written or verbal request for reconsideration within ninety (90) days of the date of CCHP's denial. CCHP will answer your written or verbal request for reconsideration within thirty (30) days of receipt. Please read below for more information on Medi-Cal Fair Hearings.</u>	1.1.4-1 The MCP must provide supporting documentation indicating that its policies/ procedures or processes have been modified to complement its member handbook revision and allow oral or telephonic filing of an appeal. <b>This finding is open.</b>	1.1.4-1 Refer to attached policy: 1) MS 8.018	1.1.4-1 The MCP provided revised policies and procedures containing the required modifications. <b>This item is closed.</b>
1.1.4-2 Revise policies and operations regarding time frames to adhere to the Contract: 45 days for resolution, with a maximum of 14 additional days if there is a need for additional information, and the delay is in the Member's interest.	1.1.4-2 Per guidance from CCHP's Contract Manager, Jonathan Prince, CCHP has obtained authorization to use 30 days rather than 45 days since this is what NCQA is requiring for accreditation. Per Jonathan, "There usually is no problem if the health plan wants to set a more exacting standard than what the state requires. Sound like in this case DHCS would have no problem with CCHP resolving appeals in 30 days to meet NCQA standards. It's only when the health plan wants a looser standard (such as 60 days to resolve appeals) that there could be an issue. Please confirm that I am understanding the issue correctly." Jonathan Prince Contract Manager - Local Initiative Unit Medi-Cal Managed Care Division Department of Health Care Services 1501 Capitol Ave, Sacramento, CA, 95814-5005 MS 4409, PO Box 997413 Sacramento, CA 95899 916-445-3589	1.1.4-2 The MCP provided adequately revised policies and procedures addressing this finding. <b>This item is closed</b>		
1.1.4-3 Follow guidelines in denial decisions and subsequent appeals.	1.1.4-3 CCHP has attached "Grievance and Appeals Retrospective File Audits" Policy #: MS 8.029 Desk Reference, to evidence that criteria, clinical guidelines or medical policies are followed in denial decisions and subsequent appeals.	1.1.4-3 The MCP must provide documentation that demonstrates that its revised policies have been implemented. <b>This item is open</b>	1.1.4-3 The evidence of implementation is the revised date on the policy. In service was given July 2013 and February 2014 on Auditing Grievances and Appeals files	1.1.4-3 The MCP provided revised policies and procedures containing the required modifications. <b>This item is closed.</b>
1.1.4-4 Characterize all	1.1.4-4 MS8.029 has also been revised to state that all	1.1.4-4	1.1.4-4	1.1.4-4

activities that dispute a Plan decision to deny, delay, or modify a requested service as appeals.	activities that dispute a plan decision to deny, delay or modify a requested service are characterized as an appeal.	The MCP must provide supporting documentation that it is appropriately characterizing as appeals all activities that dispute a Plan decision to deny, delay, or modify a requested service. <b>This item is open.</b>	Refer to attached policies: 1) MS 8.018 2) MS 8.029	The MCP provided revised policies and procedures containing the required modifications. <b>This item is closed.</b>
<b>1.1.5 RECOMMENDATIONS:</b>				
<b>1.1.5-1</b> The Plan should have formal, mutually agreed upon, delegation agreements with entities to which it delegates. These should include a description of the delegated activities, the specific delegated functions of the delegated entity and the Plan, the oversight monitoring and evaluation processes, reporting requirements, and the remedies/actions available to the Plan.	<b>1.1.5-1</b> CCHP does have a formal MOU for UM activities with CCRMC. MOU will be attached to CAP report. Additionally, it is our understanding that NCQA is in the process of granting "Kaiser deemed delegation status for Medi-Cal".	<b>1.1.5-1</b> The MCP provided an MOU that appropriately addressed this deficiency. <b>This item is closed.</b>		
<b>1.1.5-2</b> The Plan should either monitor delegated UM for over- and under-utilization, or its evaluation tools for UM should include activities related to the detection of under- and over-utilization.	<b>1.1.5-2</b> A new report to detect under and overutilization activities is being developed and should be available in October-November 2013. The new report will be able to detect these activities for the CCRMC (RMC network).	<b>1.1.5-2</b> The MCP must provide supporting documentation of a process in place to monitor delegated UM for over- and underutilization. The MCP must also provide a copy of its new report to detect under- and overutilization and respective action taken. <b>This item is open.</b>	<b>1.1.5-2</b> Refer to document: 1) Over & Under Utilization Report 2) These reports are reviewed by UM Workgroup. Concerns will be addressed as appropriate  <b>Update 7/24/14</b> <b>1.1.5-2</b> See Fact Sheet for explanation of report and QC Minutes from 4/24/14.	<b>1.1.5-2</b> The MCP provided a copy of an over and underutilization report. In order to close this finding, the MCP must provide an explanation on the meaning of this report and documentation of action taken based on its results. This item remains open.  <b>Update 7/24/14</b> The MCP submitted a fact sheet explaining the report previously submitted and Quality Council meeting minutes. The information shows ongoing actions related to under- and

				over-utilization detection. <b>This item is closed.</b>
<b>1.1.5-3</b> Repeated findings on oversight evaluations of the Kaiser network should result in a corrective action plan	<b>1.1.5-3</b> Oversight audit of Kaiser is scheduled for October 2013. Will review previous audit deficiencies during this year's audit to determine if changes were implemented and improvement made. If repeat findings occur, CAP will be requested		<b>UPDATE: 8/12/14:</b> These items were previously submitted, but were attached to another standard. We have labeled them with this standard number and uploaded.	<b>1.1.5-3 Update 7/28/14.</b> The MCP must provide a copy of the Corrective Action Plan from the audit conducted in October 2013. This item is open.  <b>Update 8/14/14</b> The MCP submitted a copy of the MCP's October 2013 Kaiser audit results. It contains the notation that a CAP for UM File Review findings was accepted from Kaiser 1/21/14. Noted no follow-up required beyond next annual audit. The MCP also submitted a copy of the Kaiser CAP tool showing the Kaiser response submissions. <b>This item is closed.</b>
<b>1.1.5-4</b> Annual oversight evaluations should be conducted on CCRMC and the Plan's PBM.	<b>1.1.5-4</b> CCHP has shared DHCS audit finding with CCRMC UM Manager and has requested that CCRMC address the findings and implement changes before the next oversight audit, which is planned for late October - early November 2013. The deficiencies identified by DHCS for CCRMC will be assessed for implementation during the upcoming oversight audit. CCHP has developed a PBM oversight tool to conduct QI evaluation of the PBM. Please see attachment "1.1.5 CCHP PBM Audit tool.pdf"		<b>UPDATE: 8/12/14:</b> These items were previously submitted, but were attached to another standard. We have labeled them with this standard number and uploaded.  CCHP has also retained a PBM auditor and will be working together on project plan. Kickoff audit project planning meeting scheduled for August 11, 2014.	<b>Update 7/28/14</b> The MCP must provide a copy of the Oversight Audit conducted in late October – early November 2013. This item is open.  <b>Update 8/14/14</b> The MCP submitted a copy of the results of the 2013 Delegation Audit which includes notations of CAPs required. The MCP also submitted responses from CCRMC to corrective action requirements. The MCP also submitted minutes from a Quality Council Meeting, February 27, 2014 showing that issues on this required CAP were discussed. <b>This item closed.</b>
<b>1.1.5-5</b> Deficiencies noted in Kaiser's and CCRMC's most	<b>1.1.5-5</b> Deficiencies noted in Kaiser last oversight audit will be reassessed during this year's audit, which is		<b>UPDATE: 8/12/14:</b> These items were	<b>Update 7/28/14</b> The MCP must

recent oversight evaluations should result in the development of a corrective action plan.	planned for October 2013. CCRMC's deficiencies identified in 2010 will be reassessed during this year's audit; and if findings are deemed a repeat finding, will require a CAP.		previously submitted, but were attached to another standard. We have labeled them with this standard number and uploaded.	provide a copy of the Corrective Action Plan generated as a result of its oversight audit conducted in October 2013. This item is open.  <b>Update 8/14/14</b> The MCP submitted a copy of the MCP's October 2013 Kaiser audit results. It contains the notation that a CAP for UM File Review findings was accepted from Kaiser 1/21/14. Noted no follow-up required beyond next annual audit. The MCP also submitted a copy of the Kaiser CAP tool showing the Kaiser response submissions. <b>This item is closed.</b>
<b>2.2.1 RECOMMENDATIONS:</b>				
<b>2.2.1-1</b> Develop and implement a policy for out-of-network coordination of care.	<b>2.2.1-1</b> UM will work in conjunction with QM to develop a report of all authorized out of plan members. Once identified, CCHP will develop a letter to these members with information about our Case Management services. If problems are identified with these members and Case Management is required, UM will refer these members to CCHP's Case Management Unit for follow-up.	<b>2.2.1-1</b> The MCP must provide policies and procedures that address out-of-network coordination of care and supporting documentation that demonstrates that this process is being implemented. Supporting documentation may include a copy of the template letter developed for authorized out of plan members. <b>This item is open.</b>	<b>2.2.1-1</b> Refer to documents: 1) UM policy 15.004-Specialty Referrals 2) Samples of 2 approval notices with provider instructions on where to send clinical notes and reports.	<b>2.2.1-1</b> The MCP provided revised policies and procedures containing the required modifications and samples of approved notices with providers' instruction. <b>This item is closed.</b>
<b>2.2.1-2</b> Develop and implement an effective monitoring system to ensure that case management	<b>2.2.1-2</b> CM16.001 Program Description has been revised to include the following referral reason: "Members receiving out-of-plan services <i>and</i> care coordination needs have been identified by the provider	<b>2.2.1-2</b> The MCP must provide supporting documentation	<b>2.2.1-2</b> 1) 2013 Identifying Members for Case Management/Access to	<b>2.2.1-2</b> The MCP provided a copy of Members Case Management/ Access to Case Management

services are provided.	or UM department.”	to demonstrate that it has developed and implemented an effective monitoring system that ensures case management services are provided. <b>This item is open.</b>	Case Management Report date 11/18/13 2) 2012-2013 Population Assessment for Contra Costa Health Plan Complex Case Management	Report date 11/18/13 as well as 2012-2013 Population Assessment. <b>This item is closed.</b>
2.2.1-3 Develop and implement a records management system that would ensure that Member records can be located	2.2.1-3 CCHP's Provider Relations will add to annual delegation audit for CCRMC an audit of completeness of medical records. For the Community Provider network, we will do a rotating quarterly audit on larger PCP provider groups. Provider records are already evaluated in advance of re-credentialing.	2.2.1-3 The MCP must provide supporting documentation that demonstrates a record management system is in place and effectively ensures medical records can be located. <b>This finding is open.</b>	2.2.1-3 Audit was performed during the transition period when CCRMC and many of our CPN providers were transitioning to EMR. The transition is complete and medical records can be downloaded to a CD for audit purposes. Rotating mid cycle on larger CPN groups. Sample MR Review. CPN Care Matters Spring 2013 pg 4.	2.2.1-3 The MCP provided a sample MR Review along with its member newsletter focusing on the issues. <b>This item is closed.</b>
<b>2.2.2 RECOMMENDATIONS:</b>				
2.2.2-1 Revise the MOU for consistency with the Plan's Policies and Procedures pertaining to roles, responsibilities, and functions	2.2.2-1 MOU has been revised to meet all policies and procedures pertaining to roles, responsibilities and functions in coordinating care with CCS.	2.2.2-1 The MCP should provide a copy of its revised MOU demonstrating changes have been incorporated to ensure the MOU is consistent with the health plan's policies and procedures regarding roles, responsibilities, and functions. <b>This item is open.</b>	2.2.2-1 Revised CCS MOU	2.2.2-1 The MCP provided a copy of its revised CCS MOU. <b>This item is closed.</b>
2.2.2-2 Develop and implement a monitoring system to ensure Members enrolled in California	2.2.2-2 For the CPN network, will monitor claims to ensure that members enrolled in CCS are still receiving medically necessary diagnostic, preventive and treatment services through their PCP. For the RMC	2.2.2-2 The MCP must provide supporting documentation demonstrating a	2.2.2-2 UM15.039- Coordination of Care for Members (desk reference)	2.2.2-2 The MCP provided revised policies and procedures containing the required

Children's Services are receiving all medically necessary diagnostic, preventive and treatment services through their Primary Care Providers.	network, CCHP will identify the children receiving CCS and run a report quarterly to ensure that they are obtaining the requisite treatment services through their PCP	system is being implemented to ensure all CCS embers are receiving medically necessary services at their primary care provider. Supporting documentation may include copies of reports for both the CPN and RMC networks that ensure members enrolled in CCS are receiving medically necessary diagnostic, preventive and treatment services through their PCPs. <b>This item is open.</b>		modifications. <b>This item is closed.</b>
<b>2.2.2-3</b> Develop and implement a monitoring system for Members receiving California Children's Services to ensure their care is coordinated between the Plan, Primary Care Providers, and CCS.	<b>2.2.2-3</b> CCHP meets quarterly with CCS to discuss coordination of care. CCHP also has a CCS liaison that has weekly meetings with CCS' designated coordinator.  1) Provide Bulletin & Provider Manual Amendment _ PCP w/ Kids in CCS are resp to maintain med necessary diagram, preventative treatment services when they get approval letter.  Either Plan or CCS sends the provider approval letter	<b>2.2.2-3</b> The MCP must provide supporting documentation demonstrating the implementation of a monitoring system for CCS care between the Plan and PCP. This may include the minutes taken of quarterly coordination meetings with CCS. <b>This item is open.</b>	<b>2.2.2-3</b> Refer to documents: 1) CCS Meeting Minutes 8-27-13 2) CCS Minutes Rev 1-24-14 3) Sample of Weekly CCS Referrals & PCP Notice Log	<b>2.2.2-3</b> The MCP provided meeting minutes for 8-27-13 and 1-24-14 as well as a sample of its CCS Referrals & PCP Notice Log. <b>This item is closed.</b>
<b>2.2.3</b> <b>RECOMMENDATIONS:</b>				
<b>2.2.3-1</b> Develop and implement a monitoring system to ensure Members enrolled EI are receiving all medically necessary diagnostic, preventive and treatment services through their Primary Care Providers.	<b>2.2.3-1</b> MOU has been revised to meet with RCEB at least quarterly to coordinate care for members and the MOU will be updated as needed. Meeting agendas and minutes will be documented each time a meeting is held.	<b>2.2.3-1</b> The MCP must provide supporting documentation demonstrating a monitoring system has been implemented that ensures members are receiving all medically	<b>2.2.3-1</b> RCEB Autism Meeting Minutes  <b>Update 7/24/14</b> <b>2.2.3-1</b> Please see attached signed and dated policy UM15.038.	<b>2.2.3-1</b> The MCP provided a RCEB meeting minutes, but DHCS requested signed policy and procedures outlining its monitoring system that ensures members are receiving all medically necessary diagnostic, preventive, and

		necessary diagnostic, preventive, and treatment services through their primary care providers. <b>This item is open.</b>		treatment services through their primary care providers. <b>This item remains open.</b>  <b>Update 7/24/14</b> The MCP submitted signed P&P UM15.038 <b>This item is closed.</b>
<b>2.2.3-2</b> Develop and implement a monitoring system for Members receiving EI/DD services to ensure care coordination between the Plan, PCPs, and RCEB.	<b>2.2.3-2</b> CCHP can generate a list of members receiving EI/DD services and analyze the claims usage for these members in ccLINK to ensure that these members are receiving the proper coordinated services.	<b>2.2.3-2</b> The MCP must provide supporting documentation that a monitoring system has been developed and implemented that ensures care coordination for members receiving EI/DD services. The MCP must also provide documentation demonstrates how it collaborates with the local RCEB as outlined in the MOU. Supporting documentation may include items mentioned in the initial CAP response. <b>This item is open</b>	<b>2.2.3-2</b> The Health Plan has had attempted (thru our Medical Contract Mgr- see attached document) to obtain additional information from the Regional Center report to pass on to our provider. Clinical details, such as services being rendered and provider of service are not on the report, which makes coordinating care difficult. Sharing and coordinating care with the PCP will be beneficial when such information is available on the report.  <b>Update 7/24/14</b> 2.2.3-2 Attached is the MOU with RCEB.	<b>2.2.3-2</b> The MCP must provide the following information in order to close this item: The MOU that outlines the collaboration with RCEB. This item remains open.  <b>Update 7/24/14</b> The MCP submitted a copy of the signed MOU between the Plan and RCEB. <b>This item is closed.</b>
<b>2.2.3-3</b> Ensure program collaboration between the Plan and RCEB as outlined in the MOU.	<b>2.2.3-3</b> CCHP discusses the coordination of care between the plan, PCPs and RCEB in quarterly meetings.		<b>UPDATE: 8/12/14:</b> Attached are autism update minutes for 11/13, 2/14 and 5/14. Also attached are Seven Cs Project Meeting Minutes Minutes. This roundtable was	<b>Update 7/28/14</b> The MCP must provide a copy of its quarterly meeting minutes containing evidence that collaboration between the Plan and RCEB as outlined in the MOU is occurring. This item is open.  <b>Update 8/14/14</b> The MCP submitted minutes from Autism Update Meetings, November

			formerly named the Interagency Council for Infant Services (ICIS referred to in Policy UM15.038.)	2013, February 2014, and May 2014. The MCP also submitted minutes from their Seven Cs Project Meetings. The information submitted shows the MCP is actively discussing issues of coordination of care with RCEB. <b>This item is closed.</b>
<b>2.2.4 RECOMMENDATIONS:</b>				
<b>2.2.4</b> Develop and implement a system to monitor Providers for IHA completion within the required time frames.	<b>2.2.4</b> We will create a report based on IHA charge codes and match it with lists of new enrollees to create compliance rates for our larger providers, semi-annually. We are piloting a prospective report with our Community Clinics to let them know who still needs an IHA. If this is useful (which depends partially on claims lag) we will produce for provider groups with poor rates of compliance with completing IHAs.	<b>2.2.4</b> The MCP must provide supporting documentation demonstrating that a system has been developed and implemented to monitor providers within the required timeframe. Supporting documentation may include evidence of items noted in the initial CAP response. <b>This item is open.</b>	<b>2.2.4</b> Our reporting unit completed a report, but the data were not correct. A similar request has been forwarded to our IS department which should have better access to the required elements. Estimated completion and implementation of monitoring system, early July 2014.  <b>Update 7/24/14</b> <b>2.2.4</b> Attached is the completed report entitled "IHA Completion Report." This was formally adopted in our BIM/CFS group with a referral to QC. Minutes are attached.  <b>UPDATE: 8/12/14:</b> Unfortunately, the name of the report is misleading. The report covers all IHA and uses the codes/methodology provided by the Department in 2004. We had several	<b>2.2.4</b> This item must remain open until evidence of completion and implementation can be provided. This item remains open.  <b>Update 7/24/14</b> The MCP submitted a report entitled: New CCHP Members with Staying Healthy Assessment (AMB3023) and minutes of the BIM/CFS group meeting. It is not clear if the SHA report would track IHA completion since the SHA is only one component of the IHA. Also, the report shows that of 24445 Medi-Cal enrollees 10459 (43%) have not completed the SHA. To close this item the MCP must provide evidence of actions taken to improve the compliance rate and evidence of improvement. This item remains open.  <b>Update 8/28/14</b> The MCP submitted a statement of actions which are in the early stage of design and

			<p>unexpected delays in getting the report going, but it is now functional. We will not be able to show improvement by 8/12/14, but the issue goes to Clinical Leadership Group on 8/14/14 and we expect concrete action items to be assigned then.</p> <p><b>Update 8/26/14:</b> Issue of improvement in IHA completion rate was referred to Clinical Leadership Group. They sent a recommendation to the Ambulatory Redesign Group of the County clinics to include calling new patients to get them to come for a well visit (and get IHA). They also recommended using the automated telephone system to call new members to encourage them to make an appointment. This request has been submitted, but it is not yet operational. They also directed staff to provide FQHCs in the community with lists of their patients who have not received IHAs. A tweak to the current report that will allow this has been requested. As these interventions are not yet in place, it is too soon to show improvement.</p> <p><b>Update 9/9/14:</b> Please see attached IHA Improvement Plan.</p>	<p>implementation. The actions include a recommendation for the County clinics to contact members by phone to encourage them to schedule, and get a "well visit (including a IHA)", and the use of an automated telephone system to call new members to encourage them to make an appointment. Additionally, a system is proposed to notify FQHCs of patients who have not received an IHA. The MCP states the processes are in the early stages, therefore no evidence of implementation or operationalization is yet available.</p> <p><b>This item is provisionally closed.</b></p>
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<b>3.3.1 RECOMMENDATIONS:</b>				
<b>3.3.1-1</b> Monitor waiting times for telephone and office and whether the first prenatal visit for a pregnant Member is available within two weeks upon request.	<b>3.3.1-1</b> For first prenatal visit, in Community Provider Network, our Social Workers who follow pregnant women will track each member's provider and whether they were able to get the initial appointment within two weeks. The data will be analyzed and presented to Quality Council regularly. For CCRMC, we will monitor the Third Next Available Appointment report for their Healthy Start program and work with CCRMC to improve access if the wait stretches beyond two weeks.	<b>3.3.1-1</b> The MCP has submitted a Provider Wait Time Survey. To close this finding, however, the MCP must provide timeframes in which the data from the survey results was collected and the actions taken were documented. <b>This item is open.</b>	<b>3.3.1-1</b> The phone and office wait data were collected July-Sept 2012. No follow up actions on it were taken because none were seen as needed	<b>3.3.1-1</b> The MCP provided a copy of the CCHP Quality Council Presentation which shows statistical data. The MCP also provided its Prenatal Access Report. <b>This item is closed</b>
<b>3.3.1-2</b> Implement actions when deficiencies to access standards are detected.	<b>3.3.1-2:</b> Evidence of monitoring telephone and office wait times and of actions taken to address access deficiencies was submitted in response to the draft audit report, but was not acknowledged in the final report. (Documents attached: "3.3.1 attachment excerpt from phone and office wait monitoring" and "3.3.1 attachment Timely Access Report 2012 see top of page 4")	<b>3.3.1-2</b> The MCP must provide supporting documentation that demonstrates the action it took based on the noted deficiencies in meeting access standards. Supporting documentation may include the development and implementation of new processes, of follow-up procedures and actions taken to correct deficiencies. <b>This item open.</b>	<b>3.3.1-2</b> Prenatal Access Report 04.2014  <b>3.3.1-2</b> Actions taken to address deficiencies in adherence to timely access standards were documented and presented to Quality Council in May 2012. That document is being submitted.	<b>3.3.1-2</b> The MCP provided an Excerpt for its Timely Access Report to the Quality Council for its May 2012 meeting. The MCP also provided its Prenatal Access Report. <b>This item is closed.</b>
<b>3.3.3 RECOMMENDATION:</b>				
<b>3.3.3</b> Improve call waiting times to comply with telephone answering time access standards outlined in policies and procedures.	<b>3.3.3</b> Decreasing our abandonment rate and average speed of answer has been our ongoing goal. We have increased the number of Advice Nurses assigned to quick screening and we have changed our phone options so if a patient is not symptomatic s/he can choose to speak to an LVN for nonmedical info. This decreases the number of nonmedical calls that need to be handled by Advice Nurses. We also increased the	<b>3.3.3</b> The MCP must provide supporting documentation demonstrating improvement on call waiting times, including statistical reports	<b>3.3.3</b> See 2013 Stats. We now have four nurses assigned to quick screening and the quick screening process is started earlier than before. We continue to have the Interim Advice	<b>3.3.3</b> The MCP provided a 2013 statistical report for Advice nurses as well as a write up on how the data they provided help in decreasing abandonment rate and average speed of answer.

	<p>number of LVN's in our unit and monitoring the number of non-medical calls to see if we need another LVN. Advice Nurses no longer conduct the lab call backs, as this is also done by the LVNs. We also have the Telephone Clinician Clinic (TCC) which also helps with call time since the nurses can refer to TCC and not spend a lot of time problem solving if there are no appointments available at the clinic. We have an interim Supervisor who also assists with Quick screening. We are monitoring the statistical reports to modify staffing to meet high call volume times.</p>	<p>demonstrating before and after call waiting times and a description of monitoring efforts that will ensure continued monitoring in this area. Supporting documentation may include a copy of the statistical report used to modify staffing to meet high call volume times. <b>This item is open.</b></p>	<p>Nurse Supervisor also assist with quick screening calls. We have increased the number of LVN's and now we have four LVN's. We have adjusted the work schedule of the LVN's in order to have LVN support off hours as well as during weekends. We have LVN coverage from 8am to 8pm Monday through Friday; 8am-5pm Saturday and Sunday. By adjusting the LVN coverage it decreases the non-medical calls going to the RN queue. We have also started having the LVN's conduct the routine follow up calls again freeing the RN's to triage the medical calls. We have expanded the Telephone Clinician Clinic (TCC) to seven days a week with two providers in the morning and two providers in the afternoon session, which also helps with call time since the nurses can refer to TCC and not spend a lot of time problem solving if there are no appointments available at the clinic. We are monitoring the statistical reports to modify staffing to meet high call volume times.</p>	<p><b>This item is closed.</b></p>
<p><b>3.3.5 RECOMMENDATIONS:</b></p>				
<p><b>3.3.5-1</b> Ensure that ER claims are paid timely as required by the Contract.</p>	<p><b>3.3.5-1</b> Medi-Cal Program timeliness guidelines as referenced by Contract 04-36067 A09, Exhibit A, Attachment 8, Sec. 5: "Plan shall pay or deny 90% of clean claims within 30 days, and 99% of clean claims by 90 days" Have been added to updated policy CLM 4.007e.</p>	<p><b>3.3.5-1</b> The MCP must provide supporting documentation demonstrating a system is in place that</p>	<p><b>3.3.5-1</b> Claims timeliness is monitored on a weekly basis and ER claims are included in total claims paid and monitored by paid claims</p>	<p><b>3.3.5-1</b> The MCP provided the requested documentation to correct the deficiency. <b>This item is closed.</b></p>

	<p>Claims monitoring and tracking guidelines have been added to updated Policy 4.007e: "Plan will monitor monthly turnaround times of claims and pull aging claims for expedited processing."</p> <p><b>3.3.5-1</b> Claims timeliness is monitored on a weekly basis and ER claims are included in total claims paid and monitored by paid claims reports. CCHP and our IT department have worked closely together to also develop report: Processed claims quarterly "TAP1481" which monitors all claims processed and indicates if any claims are paid late. This report is pulled and reviewed quarterly by claims management staff.</p>	<p>ensures the timely payment of Emergency Room claims in accordance to the contract. Supporting documentation may include an analysis of claims paid, monitoring reports, and other documentation of timely ER claims payment.</p> <p><b>This item is open.</b></p>	<p>reports. CCHP and our IT department have worked closely together to also develop report: Processed claims quarterly "TAP1481" which monitors all claims processed and indicates if any claims are paid late. This report is pulled and reviewed quarterly by claims management staff.</p>	
<p><b>3.3.5-2</b> Ensure that ER claims for Members covered by the Plan's delegated entities are forwarded in a timely manner.</p>	<p><b>3.3.5-2</b> Complete claims inventory is reviewed weekly and delegated entities claims are pulled to ensure timely forwarding of all claims including ER claims. These claims are reviewed by the claims supervisor after assignment. See procedure CLM 4.536 Kaiser member claims "All claims will be forwarded to Kaiser within 10 working days."</p>	<p><b>3.3.5-2</b> The MCP must provide supporting documentation to demonstrate it has a system in place to adequately track, monitor, and take effective action to ensure ER claims for members covered by MCP-delegated entities are forwarded in a timely manner.</p> <p><b>This item is open.</b></p>	<p><b>3.3.5-2</b> Complete claims inventory is reviewed weekly and delegated entities claims are pulled to ensure timely forwarding of all claims including ER claims. These claims are reviewed by the claims supervisor after assignment. See procedure CLM 4.536 Kaiser member claims "All claims will be forwarded to Kaiser within 10 working days."</p>	<p><b>3.3.5-2</b> The MCP provided revised policies and procedures containing the required modifications.</p> <p><b>This item is closed.</b></p>
<p><b>3.3.5-3</b> Revise Policy #: CLM 4.007, Claims Determination Timeliness, to comply with the Contract.</p>		<p><b>3.3.5-3</b> The MCP has taken steps to correct the deficiency. This issue was addressed in the P&amp;P.</p> <p><b>This item is closed.</b></p>		
<p><b>3.3.5-4</b> Monitor clean claims payment and improve timely payment processing to comply with the Contract to pay 90% of all clean claims from practitioners who are in individual or group practices</p>	<p><b>3.3.5-4</b> Complete claims inventory is reviewed weekly and assigned to staff for timely payment. These claims are reviewed by the claims supervisor after assignment. CCHP and our IT department have worked closely together to also develop report: CCHP Claims turnaround time report (TAP2552) This report in combination with our internal monitoring reports claims</p>	<p><b>3.3.5-4</b> The MCP must provide supporting documentation demonstrating it has implemented a process that ensures timely</p>	<p><b>3.3.5-4</b> Complete claims inventory is reviewed weekly and assigned to staff for timely payment. These claims are reviewed by the claims supervisor after assignment.</p>	<p><b>3.3.5-4</b> The MCP provided the requested documentation to correct the deficiency.</p> <p><b>This item is closed.</b></p>

or who practice in shared health facilities, within 30 days of the date of receipt and 99% of all clean claims within 90 days.	are in timely compliance.	claim payments in accordance with contract requirements. Supporting documentation may include examples of monthly monitoring reports that show claims were paid in a timely manner. <b>This item is open</b>	CCHP and our IT department have worked closely together to also develop report: CCHP Claims turnaround time report (TAP2552) This report in combination with our internal monitoring reports claims are in timely compliance.	
<b>3.3.6 RECOMMENDATIONS:</b>				
<b>3.3.6-1</b> Ensure that family planning claims are paid timely as required by the Contract.	Medi-Cal Program timeliness guidelines as referenced by Contract 04-36067 A09, Exhibit A, Attachment 8, Sec. 5: "Plan shall pay or deny 90% of clean claims within 30 days, and 99% of clean claims by 90 days" Have been added to updated policy CLM 4.007e. Claims monitoring and tracking guidelines have been added to updated Policy 4.007e: "Plan will monitor monthly turnaround times of claims and pull aging claims for expedited processing." <b>3.3.6-1</b> Claim timeliness is monitored on a weekly basis and Family Planning claims are included in total claims paid and monitored by paid claims reports. CCHP and our IT department have worked closely together to also develop report: Processed claims quarterly "TAP1481" which monitors all claims processed and indicates if any claims are paid late. This report is pulled and reviewed quarterly by claims management staff.	<b>3.3.6-1</b> The MCP must provide supporting documentation that demonstrates how it ensures the timely payment of family planning claims as required by the contract.  Supporting documentation may include family planning claims data analysis and corrective action taken based on the results of such analyses. <b>This item is open</b>	<b>3.3.6-1</b> Claims timeliness is monitored on a weekly basis and Family Planning claims are included in total claims paid and monitored by paid claims reports. CCHP and our IT department have worked closely together to also develop report: Processed claims quarterly "TAP1481" which monitors all claims processed and indicates if any claims are paid late. This report is pulled and reviewed quarterly by claims management staff.	<b>3.3.6-1</b> The MCP provided their Claims report monitoring ER claims demonstrating the plans ability to track and trend claim payments in accordance with contract. <b>This item is closed.</b>
<b>3.3.6-2</b> Revise Policy #: CLM 4.007, Claims Determination Timeliness, to comply with the Contract.		<b>3.3.6-2</b> The MCP has taken steps to correct this deficiency. Issue was addressed in the P&P. <b>This item is closed.</b>		<b>3.3.6-2</b> The MCP has taken steps to correct this deficiency. Issue was addressed in the P&P. <b>This item is closed.</b>
<b>3.3.6-3</b> Monitor clean claims payment and improve timely payment processing to comply with the Contract to pay 90%	<b>3.3.6-3</b> Complete claims inventory is reviewed weekly and assigned to staff for timely payment. These claims are reviewed by the claims supervisor after assignment. CCHP and our IT department have worked closely	<b>3.3.6-3</b> The MCP must provide supporting	<b>3.3.6-3</b> Complete claims inventory is reviewed weekly and assigned to staff for timely	<b>3.3.6-3</b> The MCP provided their Claims report monitoring ER claims demonstrating the plans ability

of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities, within 30 days of the date of receipt and 99% of all clean claims within 90 days.	together to also develop report: CCHP Claims turnaround time report (TAP2552) This report in combination with our internal monitoring reports claims are in timely compliance.	documentation demonstrating it has implemented its revised policies and procedures. This documentation should include clean claims data monitoring and tracking analysis and respective corrective action taken based on the results of such analyses. <b>This item is open.</b>	payment. These claims are reviewed by the claims supervisor after assignment. CCHP and our IT department have worked closely together to also develop report: CCHP Claims turnaround time report (TAP2552) This report in combination with our internal monitoring reports claims are in timely compliance.	to track and trend claim payments in accordance with contract. <b>This item is closed.</b>
<b>3.3.7 RECOMMENDATIONS:</b>				
<b>3.3.7-1</b> Monitor Emergency Departments at contracted hospitals to ensure Members have access to a sufficient supply of medications in emergency situations to last until the Member can reasonably be expected to have a prescription filled.	<b>3.3.7-1</b> Updated printed member formulary to call out availability of 24-hour Walgreens pharmacy  CCHP pharmacy director will poll random members utilizing ER and ERs about medication supplied and medication supply policy when discharging ER patients after regular pharmacy business hours.	<b>3.3.7-1</b> The MCP must provide supporting documentation demonstrating that Emergency Departments at contracted hospitals are being monitored to ensure Members have access to a sufficient supply of medications in emergency situations to last until the Member can reasonably be expected to have a prescription filled. Supporting documentation may include completed elements noted in the initial CAP response. <b>This item is open.</b>	<b>3.3.7-1</b> 1. CCHP Member Services ran a report having the following criteria: pharmacy grievances and ER providers. The report came back with no data. 2. CCHP Quality Management Unit reviewed all pharmacy grievances and there were no patient grievances which were related to post-ER discharge medication access.	<b>3.3.7-1</b> The MCP provided a summary of corrective action implemented including the availability of emergency drug supply, and relevant member services support elements. <b>This item is closed.</b>
<b>3.3.7-2</b> Implement procedures outlined in prior audit CAP.	<b>13.3.7-2 Added</b> the following to Pharmacy policy and procedure PM6-010: "To monitor if members have access to a sufficient supply of medications in emergency situations to last until the member can reasonably be expected to have a prescription filled,	<b>3.3.7-2</b> The MCP must provide a supporting documentation indicating its revised Pharmacy policy and	<b>3.3.7-2</b> See 3.3.7-1  <b>Update 7/24/14</b> <b>3.3.7-2</b> Attached is the signed and	<b>3.3.7-2</b> The MCP must provide its Emergency Supply Plan policy and procedure to allow 5-day emergency supplies of medications.

	<ol style="list-style-type: none"> <li>1. CCHP will review the policy and procedure of the emergency room at the contracted hospital. If warranted</li> <li>2. CCHP will randomly select and review Emergency Department claims to determine if prescribed medications were dispensed in sufficient quantities.</li> <li>3. Contra Costa Health Service's electronic medical record, through its Client Relationship Manager function is able to report and track aggregated calls that are specific to not receiving drugs in cases of an emergency."</li> </ol> <p>Please see attachment "3.3.7 PM6-010 Pharmacy services (revised 11-12).docx.doc"</p>	<p>procedure PM6-010 is being implemented. <b>This item is open.</b></p>	<p>dated Emergency Supply Plan policy.</p>	<p>This item remains open.  <b>Update 7/24/14</b> The MCP submitted approved P&amp;P PM6.010 <b>This item is closed.</b></p>
<b>4.4.1 RECOMMENDATIONS:</b>				
4.4.1-1 Provide review and analysis to quality assurance committee to take appropriate action to remedy any problems.	4.4.1-1 Quarterly reports on member grievances and appeals are presented to Quality Council. These reports are designed to show noticeable trends and/or deficiencies	4.4.1-1 The MCP must provide supporting documentation that show it is implementing new processes. Supporting documentation may include Quarterly reports, and Quarterly Quality Council meeting minutes. <b>This item is open.</b>	4.4.1-1 New categories have been added to the grievance report, a new chart of volume per 1000 members was added, and additional analysis is sometimes included. Example reports are being submitted, plus QC minutes discussing them.	4.4.1-1 The MCP provided multiple Quarterly reports, Quarterly Quality Council meeting minutes to show as proof it is implementing a new process. <b>This item is closed.</b>
4.4.1-2 Follow-up with Providers with multiple uncommon grievances.	4.4.1-2 Medical Director reviews all clinical grievances. We will follow up with providers as appropriate, such as for multiple uncommon grievances	4.4.1-2 The MCP must provide supporting documentation that demonstrates it has a system in place that ensures consistent follow-up with providers who present multiple uncommon grievances and that this system is effectively monitored	4.4.1-2 The report of counts of multiple grievances per provider and data on the grievances is being submitted. The Medical Director uses these data to determine what follow up is needed. Refer also to attached policies:  1) MS 8.029 2) MS 8.001	4.4.1-2 The MCP provided revised policies and procedures containing the required modifications. <b>This item is closed.</b>

		and implemented. <b>This item is open.</b>		
<b>4.4.1-3</b> Ensure clinical monitoring of grievance classification by MSR.	<b>4.4.1-3</b> With the implementation of the EPIC system 7/2012 all member Grievances ( 100%) were set up to automatically be sent to Quality Management RN to determine if they are clinical in nature e.g. quality of care issues. These grievances are then handled by the Quality Management RN in consultation with the Medical Director	<b>4.4.1-3</b> The MCP must provide supporting documentation demonstrating processes are in place and implemented that ensure clinical monitoring of grievance classification by an MSR. <b>This item is open.</b>	<b>4.4.1-3</b> Refer to attached policy: 1) MS 8.001  2) Epic Grievance Flow	<b>4.4.1-3</b> The MCP provided its Epic Grievance Flow and revised policies and procedures containing the required modifications. <b>This item is closed.</b>
<b>4.4.1-4</b> Ensure resolution letters address all issues raised in the grievance and the response is clear and concise.	<b>4.4.1-4</b> See policy MS8.029 See policy MS8.001	<b>4.4.1-4</b> The MCP adequately modified its policies and procedures to address this deficiency. To close this finding, however, the MCP must provide a sample of three actual resolution letters generated after the policy change that demonstrate the health plan's system is now generating resolution letters that address all issues raised in the grievance and that the response is clear and concise. <b>This item is open.</b>	<b>4.4.1-4</b> Refer to attached documents:  1) Khoury Svc. Denied 2) Theophilou Svc. Denied 3) Fedele Svc. Denied	<b>4.4.1-4</b> The MCP provided three actual resolution letters generated after the policy change that demonstrate the health plan's system is now generating resolution letters that address all issues raised in the grievance. <b>This item is closed.</b>
<b>4.4.1-5</b> Correct errors in <i>Policy #: MS 8.001, Handling of Complaints and Grievances.</i>		<b>4.4.1-5</b> The MCP has corrected minor error modifications in its policy over the handling of complaints and grievances. <b>This item is closed.</b>		<b>4.4.1-5</b> The MCP has corrected minor error modifications in its policy over the handling of complaints and grievances. <b>This item is closed.</b>

<b>4.4.3 RECOMMENDATION:</b>				
4.4.3 Ensure timely DHCS notification of all PHI breaches as required by the Contract.	4.4.3 See policy MS8.045	4.4.3-1 The MCP has taken steps to incorporate policy changes to address this finding. <b>This item is closed.</b>		4.4.3-1 The MCP has taken steps to incorporate policy changes to address this finding. <b>This item is closed.</b>
<b>5.5.1 RECOMMENDATIONS:</b>				
5.5.1-1 Implement an organized, data driven process of Quality Improvement and have it reflected in the Quality Council Minutes. Document the flow of monitoring, identification of root causes, barriers, and prioritized actions from meeting to meeting.	5.5.1-1 We may have already fixed this because an NCQA reviewer found that we meet such standards. We will take special care to document identification of root causes and barriers and the actions taken to address them and to show that the Council gets follow up reporting so they can ensure progress toward goals.	5.5.1-1 The MCP indicated the NCQA reviewer found the MCP met this standard. To close this finding, however, the MCP must demonstrate its compliance during the audit scope period; the MCP must provide documentation indicating the MCP has established an organized data-driven process demonstrating the implementation of this process that includes the flow of monitoring, identification of root causes, barriers, and prioritized actions from meeting to meeting. This finding is deemed open.	5.5.1-1 Examples submitted.  <i>QC minutes (ANV.HEDIS.UM)</i>	5.5.1-1 The MCP provided the meeting minutes that covers the items requested by DHCS. <b>This item is closed..</b>
5.5.1-2 Document actions in areas of importance to the Plan as resulting in improvement in repeat analysis and action planning.	5.5.1-2 We may have already fixed this because an NCQA reviewer found that we meet such standards. We will take special care to document identification of root causes and barriers and the actions taken to address them and to show that the Council gets follow up reporting so they can ensure progress toward goals	5.5.1-2 The MCP must provide supporting documentation examples that show it has implemented improvement actions	5.5.1-2 Examples submitted. <i>QC Minutes</i>	5.5.1-2 The MCP provided the meeting minutes that covers the items requested by DHCS. <b>This item is closed</b>

		and corresponding follow-up repeat analysis to verify continued improvement. <b>This item is open.</b>		
<b>5.5.1-3</b> Improve Kaiser representation on the Quality Council.	Bullet 3: We made telephonic participation possible, and the Kaiser representative has been participating regularly.	<b>5.5.1-3</b> The MCP has indicated progress in this area. However, to close this finding, the MCP must provide documentation demonstrating Kaiser representative has been participating regularly. <b>This item is open</b>	<b>5.5.1-3</b> Submitting attendance record beginning when we implemented joining the meeting by phone.  <i>KaiserRegAttendance@QC</i> <i>2<sup>nd</sup> half 2013</i>	<b>5.5.1-3</b> The MCP provided the meeting minutes that covers the items requested by DHCS. <b>This item is closed.</b>
<b>5.5.2</b> <b>RECOMMENDATION:</b>				
<b>5.5.2</b> Perform re-credentialing activities and document all the features as required by <i>Policy #: CR 11.002, Practitioner Re-credentialing Process.</i>	<b>5.5.2</b> Performance monitoring was being done at the time of audit, but not documented accurately in the policy or meeting minutes. Policy revised to accurately reflect the recredentialing activities. Future meeting minutes will document the monitoring activities.	<b>5.5.2-1</b> The MCP must provide supporting documentation, including meeting minutes demonstrating recredentialing activities are being performed <b>This item is open.</b>	<b>5.5.2-1</b> Recredentialing Policy, Credentialing Meeting Minutes - April 2014/Credentialing Meeting Minutes - February 2014/Credentialing Meeting Minutes - January 2014	<b>5.5.2-1</b> The MCP provided the requested documentation to correct the deficiency. <b>This item is closed.</b>
<b>5.5.3</b> <b>RECOMMENDATION:</b>				
<b>5.5.3</b> Monitor access with a standard metric, such as third available appointment.	<b>5.5.3</b> The Third Next Available Appointment report was being worked on while the audit was taking place. It has been distributed monthly for several months.	<b>5.5.3-1</b> The MCP must provide supporting documentation that a monitoring matrix is in use. Supporting documentation must include a copy of the monthly Third Available Appointment tool and evidence of appropriate action taken on the report results. <b>This item is open.</b>	<b>5.5.3-1</b> Submitting Third next Available Appointment report. Action taken is the same as section 3.3.1-2.	<b>5.5.3-1</b> The MCP provided its Third next Available Appointment report <b>This item is closed.</b>

5.5.4 RECOMMENDATIONS:				
5.5.4-1 Implement an effective QI program for all services regardless of the number of contracting and subcontracting layers between the Plan and the Provider.	5.5.4-1 We have increased the amount of reporting from both CCRMC and Kaiser to improve our oversight.	5.5.4-1 The MCP must provide supporting documentation demonstrating quality improvement process are implemented and monitored and that actions are being taken based on quality monitoring activities. <b>This item is open.</b>	5.5.4-1 See example of report showing oversight of CCRMC improvement activities.	5.5.4-1 The MCP provided its Ambulatory Care Redesign Report - March 2014. <b>This item is closed.</b>
5.5.4-2 Execute formal, mutually agreed upon, delegation agreements with entities to which it delegates. Include a description of the delegated activities, the specific delegated functions of the delegated entity and the Plan, the oversight monitoring and evaluation processes, reporting requirements, and the remedies and actions available to the Plan.	5.5.4-2 We are currently drafting a specific delegation agreement with Kaiser, covering all required elements. When complete, we will adapt for a CCRMC agreement.	5.5.4-2 The MCP must provide supporting documentation of signed delegation agreements in place that include a description of the delegated activities, the specific delegated functions of the delegated entity and the Plan, the oversight monitoring and evaluation processes, reporting requirements, and the remedies and actions available to the Plan. <b>This item is open.</b>	5.5.4-2 Signed agreements submitted.	5.5.4-2 The MCP provided A sign copy of the delegation agreement. <b>This item is closed.</b>
5.5.4-3 Perform annual delegation evaluations once a year at CCRMC. Monitor Corrective Actions for effectiveness.	5.5.4-3 CCRMC will be audited in October. A corrective action plan will be developed and progress will be monitored by our QC and through the Quality Director's reports to CCRMC's Patient Safety and Performance Improvement Committee.	5.5.4-3 The MCP must provide supporting documentation demonstrating that it conducts annual delegation evaluations and that respective corrective actions are monitored, followed up,	5.5.4-3 Submitting audit findings, required CAPs, and references from QC minutes	5.5.4-3 The MCP provided a copy of its 2013 Delegation Audit of CCRMC/HC. <b>This item is closed.</b>

		and adequately addressed. <b>This item is open.</b>		
<b>5.5.4-4</b> Ensure that CCRMC's QI Program adequately addresses access and availability to practitioners and uses all existing data to verify that Members are not subjected to barriers to access of care.	<b>5.5.4-4</b> These items are in the CAP currently being addressed with CCRMC and progress will be tracked as described immediately above.	<b>5.5.4-4</b> The MCP must provide supporting documentation demonstrating that CCRMC's QI Program adequately addresses access and availability to practitioners and uses all existing data to verify that Members are not subjected to barriers to access of care. <b>This item is open.</b>	<b>5.5.4-4</b> CCRMC recently submitted to us an update demonstrating that they are looking at various measures related to access to care and the improvement actions they have been undertaking.  See document, 5.5.4-4 Access report from CCRMC	<b>5.5.4-4</b> The MCP provided a copy of CCRMC Access improvement report. <b>This item is closed</b>
<b>5.5.4-5</b> Conduct Annual QI oversight evaluations at the PBM.	<b>5.5.4-5</b> CCHP has developed a PBM oversight tool to conduct QI evaluation of the PBM. Please see attachment "1.1.5 CCHP PBM Audit tool.pdf"	<b>5.5.4-5</b> The MCP must provide supporting documentation that demonstrates annual QI oversight evaluations are conducted over its PMB. <b>This item is open.</b>	<b>5.5.4-5</b> In addition to the PBM oversight tool to conduct QI evaluation of the PBM we previously submitted, we are attaching the most recent evaluation conducted by our Pharmacy Director. Please see 2013 PerformRx UM15 Scoring.	<b>5.5.4-5</b> The MCP provided additional information with the scoring of its delegate PerformRx UM15. <b>This item is closed</b>
<b>5.5.5 RECOMMENDATION:</b>				
<b>5.5.5</b> Develop and implement monitoring system to ensure that medical records are consistently completed and maintained in accordance with the provisions of the Contract, CCHP Policies and Procedures, and CCR, Title 22 section 53861.	<b>5.5.5</b> Will add to annual delegation audit for CCRMC an audit of completeness of medical records. For the Community Provider network, we will do a rotating quarterly audit on larger PCP provider groups. Provider records are already evaluated in advance of recredentialing.	<b>5.5.5</b> The MCP must provide supporting documentation indicating that it is taking steps to ensure that medical records are consistently completed and maintained in accordance with the provisions of the Contract, CCHP Policies and	<b>5.5.5</b> Audit was performed during the transition period when CCRMC and many of our CPN providers were transitioning to EMR. The transition is complete and medical records can be downloaded to a CD for audit purposes. Rotating mid cycle on larger CPN groups. Sample MR Review.	<b>5.5.5</b> The MCP provided their CPN Care Matters Spring 2013 newsletter which depicted the four most common missed items in adult records. <b>This item is closed.</b>

		Procedures, and CCR, Title 22 section 53861. <b>This item is open.</b>	CPN Care Matters Spring 2013 pg 4.	
<b>5.5.6 RECOMMENDATION:</b>				
<b>5.5.6</b> Develop and implement system to ensure that all Informed Consents are done according to CCR, Title 22, sections 51305.1, 51305.3, and CCHP <i>Policy #: QM14.602, Consent for Sterilization Procedures.</i>	<b>5.5.6</b> CCHP Provider Relations will ensure that education efforts are being made with all community providers who perform sterilization procedures. CCHP's QM Department will do a focused audit on larger provider groups to ensure compliance.	<b>5.5.6</b> The MCP must provide supporting documentation that it has developed and implemented a system to ensure that all Informed Consents are processed in compliance with CCR, Title 22, sections 51305.1 and 51305.3, and CCHP <i>Policy #: QM14.602, Consent for Sterilization Procedures.</i> <b>This item is open.</b>	<b>5.5.6</b> Booklet Permanent Sterilization EngMale_L3/ Booklet Permanent Sterilization_EngFemale/ Informed Consent for Sterilization/PM-330_Eng-SP  We have a plan in place, including identified nursing staff, and codes for running a report of procedures we want to audit. The staff have been occupied with HEDIS data collection; they will begin semi annual audits in June 2014.	<b>5.5.6</b> The MCP provided copies of its booklet, request forms and a letter to all Contracted OB/GYN Providers. <b>This item is closed.</b>
<b>6.6.3 RECOMMENDATION:</b>				
<b>6.6.3</b> Ensure CCRMC performs corrective action to comply with Health Education Program requirements.	<b>6.6.3</b> Two of the four items have been corrected: member participation data and a contact person. We are currently evaluating the gap between what is offered and what is needed and will require a plan to close the gap. We are also working on posting available resources in the clinics and on the website.	<b>6.6.3</b> The MCP must provide supporting documentation of actions it has taken to ensure CCRMC is performing corrective actions to comply with the Health Education Program requirements. <b>This item is open.</b>	<b>6.6.3</b> CCRMC submitted CAP required by most recent delegation audit. The corrective action has a due date of July 15, 2014. CAP and reference to follow up in QC minutes uploaded.	<b>6.6.3</b> The MCP provided a copy of its Health Education CAP along with Quality Council Meeting Minutes. <b>This item is closed.</b>
<b>6.6.4 RECOMMENDATION:</b>				
<b>6.6.4</b> Ensure new Provider training is conducted within ten working days after the Plan places the Provider on active status as required by	<b>6.6.4</b> Providers will be notified by a phone call, e-mail or letter after approval by Peer Review and Credentialing committee to schedule an orientation within ten working days after being placed in active status.	<b>6.6.4</b> The MCP must provide supporting documentation that demonstrates the	<b>6.6.4</b> Credentialing New Provider Orientations/ Credentialing PPL 1.14.14	<b>6.6.4</b> The MCP provided a copy of its Credentialing New Provider Orientations Manual along with a copy of its January 214, 2014

the Contract.		actions it has taken to ensure new providers receive training within ten working days after the Plan places the provider on active status, as required by the Contract. <b>This item is open.</b>		Peer Review and Credentialing Committee. <b>This item is closed.</b>
<b>6.6.5 RECOMMENDATION:</b>				
<b>6.6.5</b> Implement its policies and procedures to undertake a more proactive fraud and abuse detection and intervention program.	<b>6.6.5</b> Meetings with HMS on implementation are occurring weekly with HMS and CCHP staff. CCHP has obtained approval for the lock box and will report this the week of August 26, 2013. The CFS meeting will include a standing agenda for FWA updates and HMS implementation status checks. CCHP Pharmacy director has been assisting IT with relevant identification of pharmacy claim elements so fraud/abuse detection contractor can monitor Rx claims to look for patterns of fraud and abuse.	<b>6.6.5</b> The MCP must provide supporting documentation that demonstrates actions it has taken to ensure its organization implements its established policies and procedures and establishes a more proactive fraud and abuse detection and intervention approach. <b>This item is open.</b>	<b>6.6.5</b> HMS/CCHP Joint implementation meeting minutes for April 2014.  BIM/CFS Meeting Minutes for January –April 2014.	<b>6.6.5</b> The MCP provided numerous meeting minutes depicting the implementation of its established P&Ps. <b>This item is closed.</b>

Contract Number 03-75796 (State Supported Services)

DEFICIENCIES IDENTIFIED	PLAN OF ACTION	DHCS 1st COMMENTS	CCHP 2nd RESPONSE	DHCS 2 <sup>nd</sup> COMMENTS
<b>1.1.1 RECOMMENDATIONS:</b>				
<b>1.1.1-1</b> Revise policies and procedures to remove language that implies any restriction for Member self-referral to any Medi-Cal Provider for abortion services or that prior authorization or referral is required.	These issues have been placed on the Agenda for the October Joint meeting with Kaiser for discussion. <b>1.1.1-1</b> Policy and Procedures have been updated: CLM Policy 4.007e 2, H "Claims for sensitive services: For the Medi-Cal Program: CCHP does not require prior authorization or parental consent for sensitive services, and members may self-refer to any qualified, willing Medi-Cal provider for sensitive services." CLM Procedure 4.573e Sensitive Services: HIV, Family Planning & Sexually Transmitted Disease "Per Medi-Cal, the following services and billing codes	<b>1.1.1-1</b> The MCP must provide supporting documentation to show that it has revised its policies and procedures to remove language that implies any restriction for member self-referral to any Medi-Cal Provider	<b>1.1.1-1</b> Policy and Procedures have been updated: <ul style="list-style-type: none"><li>• <i>Policy #: UM15.003, Prior Authorization</i></li><li>• CLM Policy 4.007e 2, H "Claims for sensitive services: For the Medi-Cal Program: CCHP does not require prior</li></ul>	<b>1.1.1-1</b> Although the MCP indicated modifications were made, the MCP submission was missing documentation demonstrating such changes were made. The MCP must

	are covered under family planning services. Therefore, <u>in accordance to the OB/GYN/Sensitive Services</u> grid, no authorization is required.”	for abortion services or that prior authorization or referral is required. <b>This item is open.</b>	authorization or parental consent for sensitive services, and members may self-refer to any qualified, willing Medi-Cal provider for sensitive services.” <ul style="list-style-type: none"> <li>• CLM Procedure 4.573e Sensitive Services: HIV, Family Planning &amp; Sexually Transmitted Disease “Per Medi-Cal, the following services and billing codes are covered under family planning services. Therefore, <u>in accordance to the OB/GYN/Sensitive Services</u> grid, no authorization is required.”</li> <li>• CLM Procedure 4.503e Abortion Services “MEDI-CAL (RMC/CPN/KAISER) including SNPw/ CCHP m-cal: Can go to any Medi-Cal provider without authorization. Every Medi-cal member is assured the freedom to choose a qualified family planning provider both within and outside our network of providers.”</li> </ul> <p><b><u>UPDATE: 8/12/14: Abortion documents re-sent on 7/29/14.</u></b></p>	provide supporting documentation. This item is open. <p><b>Update 7/29/14</b> The MCP submitted copies of Policy UM 15.003, CLM Policy 4.007e2,H, CLM Procedures 4.573e, and CLM Procedure 4.503e. All documents contain the required statements that Medi-Cal enrollees may self-refer for abortion services and that no prior authorization or referral is needed. <b>This item is closed.</b></p>
1.1.1-2 Revise Kaiser CCHP Member Handbook to inform Members that abortion services may be obtained from any Medi-	1.1.1-2 CLM Procedure 4.503e Abortion Services “MEDI-CAL (RMC/CPN/KAISER) including SNP w/ CCHP m-cal: Can go to any Medi-Cal provider without authorization. Every Medi-cal member is assured the	1.1.1-2 The MCP must provide evidence that it has revised the Kaiser CCHP	1.1.1-2 2014 Contra Costa Redline 2.8.14 Kaiser EOC is attached.	1.1.1-2 Although the MCP indicated modifications were

<p>Cal Provider and are not restricted to Kaiser Providers, Kaiser contracted Providers, or CCHP contracted Providers.</p>	<p>freedom to choose a qualified family planning provider both within and outside our network of providers.”</p>	<p>Member Handbook to inform Members that abortion services may be obtained from any Medi-Cal provider and are not restricted to Kaiser’s network providers, Kaiser contracted providers, or CCHP contracted providers. <b>This item is open.</b></p>	<p><b><u>UPDATE: 8/12/14:</u></b> <b><u>Abortion documents re-sent on 7/29/14.</u></b></p>	<p>made, the MCP submission was missing documentation demonstrating such changes were made. The MCP must provide supporting documentation. This item is open.</p> <p><b>Update 7/29/14</b> The MCP submitted a draft of the Kaiser EOC which contains the required language stating that Kaiser covers abortion services provided by non-Kaiser providers. <b>This item is closed.</b></p>
<p><b>1.1.1-3</b> Monitor Kaiser’s access to abortion services to ensure Kaiser implements and allows the Member’s right to use out-of-Kaiser network Medi-Cal Providers for abortion services</p>	<p><b>1.1.1-3</b> CLM Procedure 4.503e Abortion Services “MEDI-CAL (RMC/CPN/KAISER) including SNP w/ CCHP m-cal: Can go to any Medi-Cal provider without authorization. Every Medi-cal member is assured the freedom to choose a qualified family planning provider both within and outside our network of providers.”</p>	<p><b>1.1.1-3</b> The MCP must provide supporting documentation that it is monitoring Kaiser’s access to abortion services to ensure Kaiser implements and allows the Member’s right to use out-of-Kaiser network Medi-Cal providers for abortion services. <b>This item is open.</b></p>	<p><b>1.1.1-3</b> Kaiser Delegation Audit 10/2013 findings: During delegation audit it was found that the family planning policy was compliant, but needed updating. CCHP will be adding this review to our claims audit tool in our next audit of Kaiser.</p> <ul style="list-style-type: none"> <li>• See SCFHP Audit document, Section V. “Policy: Family Planning and Sensitive Services <b>Finding:</b> Policy was last revised in 2009 and is out of date. This policy needs to be revisited and brought up to date to reflect: (1) The Family Planning ICD-9 diagnosis codes currently listed in the Family Planning section of the <i>Medi-Cal Provider Manual</i>; (2) ICD-9 diagnosis</li> </ul>	<p><b>1.1.1-3</b> Although the MCP indicated modifications were made, the MCP submission was missing documentation demonstrating such changes were made. The MCP must provide supporting documentation. This item is open.</p> <p><b>Update 7/29/14</b> The MCP submitted a Claims Audit Tool Workbook , however no narrative explanation of how this tool is used to track/monitor Kaiser’s access to</p>

			<p>codes for sexually transmitted infections and for abortions as currently found in the <i>2013 ICD-9 CM International Classification of Diseases.</i>"</p> <p><b><u>UPDATE: 8/12/14:</u></b> <b><u>Abortion documents re-sent on 7/29/14.</u></b></p> <p><b>UPDATE: 09/09/14:</b> CCHP attends a delegation audit of Kaiser which occurs annually in October. Sensitive and Abortion service claims are audited based on the claims universe provided by Kaiser. We also have included copies of Kaisers updated policies on sensitive svcs/Abortion svcs: 4.0 Outside Medical Referrals and Second Opinion #UM 4.0 Rev. 5-11 States "2.10 Medical Managed Care members may choose to access certain services both in-Plan and out-of-Plan, without prior authorization. These services include: 2.10.1 Family planning services, including pregnancy testing and counseling, and abortions 2.10.2 Sensitive Services/Minors which are medically necessary services for family planning, STDs HIV/AIDS, sexual assault and abortions 2.10.3 STD services for diagnosis and treatment through local health department (LHD) clinics, family planning clinics, or through other community STD service providers. For community providers other than LHD and family planning providers, out-</p>	<p>abortion services is included. The MCP submitted Contra Costa Health Plan Delegation Audit Summary: Kaiser October 2013 Audit, however no specific information about Kaiser's access to abortion services is contained in the document. The MCP submitted a copy of Santa Clara Family Health Plan's, an audit partner, Medical Claims Audit, October 15, 2013, of Kaiser. The audit findings concern the inclusion of proper ICD codes for claims payment. It appears that this information does not speak to abortion services access, or needs an explanation of how it is germane to the DHCS finding. <b>This item is provisionally closed.</b></p>
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			<p>of-Plan services are limited to one office visit per disease episode. Follow-up care shall be provided in-Plan. 2.10.4 HIV/AIDS Testing and Counseling, in-Plan and through the out-of-Plan local LHD and family planning providers.", 21.0 Internal Referrals &amp; Consultations #UM 21.0 Rev. 5-11 States"3.0 Medi-Cal Managed Care 3.1 Medi-Cal Managed Care members may choose to access certain services both in-Plan and out-of-Plan, without prior authorization. These services include: 3.1.1 Family planning services, including pregnancy testing and counseling, and abortions 3.1.2 Sensitive Services/Minors which are medically necessary services for family planning, STDs HIV/AIDS, sexual assault and abortions. 3.1.3 STD services for diagnosis and treatment through local health department (LHD) clinics, family planning clinics, or through other community STD service providers. For community providers other than LHD and family planning providers, out-of-Plan services are limited to one office visit per disease episode. Follow-up care shall be provided in-Plan. 3.1.4 HIV/AIDS Testing and Counseling, in-Plan and through the out-of-Plan local LHD and family planning providers." We have also requested a monitoring report be provided by Kaiser at the annual delegation audit. We</p>	
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			are requesting the report include all claim information such as diagnosis, procedure codes, payment information and timeliness of claim processing.	
<p><b>1.1.1-4</b> Ensure Kaiser's contract requires that Members are allowed to self-refer to any Medi-Cal Provider outside the Kaiser or CCHP network without prior authorization.</p>		<p><b>1.1.1-4</b> The MCP must provide documentation demonstrating that it has revised Kaiser's contract language to indicate that Members may self-refer to any Medi-Cal Provider outside the Kaiser or CCHP network without prior authorization. <b>This item is open.</b></p>	<p><b>1.1.1-4</b> Kaiser Service contract language states:  Kaiser Contract L-3 Paragraph T.16.: "Information on the member's right to seek certain family planning services from any qualified provider of family planning services."  <b><u>UPDATE: 8/12/14:</u></b> <b><u>Abortion documents re-sent on 7/29/14.</u></b></p>	<p><b>1.1.1-4</b> Although the MCP indicated modifications were made, the MCP submission was missing documentation demonstrating such changes were made. The MCP must provide supporting documentation. This item is open.  <b>Update 7/29/14</b> The MCP submitted a copy of the contract signature page and the page that contains language stating Kaiser is to provide information concerning the Member's right to seek certain family planning services from any qualified provider. The active dates of the contract fall within the audit period. <b>This item is closed.</b></p>

SUBMITTED BY: PATRICIA TANQUARY, MPH, PhD

DATE: MAY 21, 2014

TITLE: CHIEF EXECUTIVE OFFICER, CONTRA COSTA HEALTH PLAN