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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Ms. Norma Diaz
Chief Executive Director
CHG Foundation, dba: Community Health Group Partnership
740 Bay Boulevard
Chula Vista, CA 91910

April 13, 2016

RE: Department of Health Care Services Medical Audit

Dear Ms. Norma Diaz:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Community Health Group, a Managed Care Plan (MCP), from June 22, 2015 through July 3, 2015. The survey covered the period of April 1, 2014 through March 31, 2015.

On, April 12, 2016, the MCP provided DHCS with additional information to its Corrective Action Plan (CAP) in response to the report originally issued on December 23, 2015. At this time, all deficiencies have been reviewed and are deemed either closed or provisionally closed.

Provisionally closed deficiencies indicate that DHCS has conditionally accepted the MCP's plan of action being proposed and/or implemented in order to bring a deficiency into compliance. For this CAP, two (2) deficiencies have been provisionally closed. DHCS will continue to monitor and/or follow-up on deficiencies that have been provisionally closed.

All other items have been reviewed and found to be in compliance. The CAP is hereby closed. The enclosed report will serve as DHCS' official 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, please contact Jeanette Fong, Chief, Compliance Unit, at (916) 449-5096 or CAPMonitoring@dhcs.ca.gov.

Original Signed by Jeanette Fong

Sincerely,
Jeanette Fong, Chief
Compliance Unit

Enclosures: Attachment A CAP Response Form

cc: OZ Kamara, 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 Name: Community Health Group Partnership Plan

Review/Audit Type: DHCS A&I Medical Review Audit **Review Period:** April 1, 2014 through March 31, 2015

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.

CORRECTIVE ACTION PLAN FORMAT

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
1. Utilization Management				
1.2 PRIOR AUTHORIZATION REVIEW REQUIREMENTS **1.2.1 Prior Authorization Time Frames** The Plan is required to process routine medical Prior Authorizations (PAs) within five working days from receipt of the information reasonably necessary to render a decision, but, no longer	This issue has been corrected. Corrective actions were completed during the last week in June 2015. **RESOLUTION:**	1.2.1 Prior Auth & Review Reqs	Corrective actions were completed during the last week in June	**1.2.1** 2/12/16 – CHG submitted: -Evidence of training that shows prior authorization

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
than 14 calendar days from the receipt the request. The decision may be deferred and the time limit extended an additional 14 calendar days only when the member or the member's provider requests an extension or the need for additional information is in the member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such. *[Contract, Exhibit A, Attachment 5 (3)(H)J* The Plan did not consistently meet time frames to process Prior Authorizations. A sample of sixteen medical PAs was examined as part of the verification study. Four medical PAs were processed 42 to 116 days after the receipt of request. The four medical PAs were associated with power-assisted wheelchairs. The Plan implemented a new procedure to confirm that the members met the medical necessity requirements. The new procedure included an in-home physical therapy evaluation. This resulted in the delay of the PA decision. **RECOMMENDATION:** 1.2.1 Process medical prior authorization requests according to required time frames.	• Desktop processes and training curriculum were reviewed and updated as needed. • Additional staff was hired and trained. • Current staff was retrained. • The process for prioritizing the workload was updated and a monitoring process was developed to ensure success. • Tools were developed to monitor and manage the inventory of requests. • Improved external relationships with providers by engaging high volume sites in discussion. • Conducted training with community case managers to assure knowledge of the process and to implement consistent communication and real time feedback. **ONGOING OVERSIGHT:** In order to ensure that this issue does not occur again Medical Management is: 1. Managing a daily dashboard that keeps track of the daily process and inventory. This report is used by management.		2015.	processing timeframes are consistent with contractual requirements. -Since 4 deficient files were related to power-assisted wheelchairs, CHG submitted a desktop procedure ("Custom Wheelchairs & Power Mobility Devices") which shows that if a PT evaluation is needed, the PA will be pended. -An audit tool review form ("Non-Certification Review Sheet") which indicates that timeframes for decision making are being monitored. -Logs for November 2015 which show turnaround times in compliance with required timeframes. -Quarterly audit results for April, June, and November 2015 ("CHG Denial File Audit Summary Sheet) which show compliance rates of 93%-100% for select files reviewed. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	2. Meeting daily with department staff occurs each morning to ensure that daily direction and priority is established. 3. Conducting audits of the key components of the process regularly to assure compliance. 4. Conducting an inter rater reliability activity that assists with identifying any inconsistencies in decision making.			
2. Case Management and Coordination of Care				
2.4 INITIAL HEALTH ASSESSMENT **2.4.1 Initial Health Assessments** The Plan is required to ensure the provision of an Initial Health Assessment (IHA) in conformance with *California Code of Regulations, Title 22, § 53910.5 (a)(1)* to each new member within 120 calendar days of enrollment. *[Contract, Exhibit A, Attachment 10 (3)(A)J* The Plan did not ensure that members receive IHAs within 120 calendar days of enrollment. The Plan's *Policy CQ 7615, Initial Health Assessments*, states the Plan will cover and ensure the provision of an IHA for all new members age 18 months and older within 120 calendar days of enrollment. The Plan sends welcome letters explaining IHA	This issue has been corrected. Corrective actions were completed during the last week in June 2015. **RESOLUTION:** • Improved the process to track and monitor members who need an IHA. • Developed a process to identify providers with high member assignment who are willing to complete IHAs in offices for incentives. • Increased communication with members about the process and scheduling. • Engaged internal	2.4.1 & 2.4.2 IHAs (1) 2.4.1 & 2.4.2 IHAs (2)	Corrective actions were completed during the last week in June 2015.	**<u>2.4.1</u>** 2/12/16 – CHG submitted: -P&P 7615 which is consistent with the required timeframe for IHA completion. Policy delineates monthly and quarterly monitoring activities by the Corporate Quality Coordinator. -A template letter dated 3/15/16 that was drafted to send to providers' offices notifying them of members who have not yet completed the IHA.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
requirements to new members to encourage initial appointments. However, the Primary Care Physicians (PCPs) schedule the IHAs. The Plan tracks member contacts through Member Services, medical records, and New Member Enrollment Rosters. PCPs access the enrollment rosters for purposes of contacting members to schedule the IHA. During provider site interviews, the consistent practice of active encouragement for IHA appointments was not found. Although some providers used information from enrollment rosters to contact newly enrolled members for IHA appointment scheduling, other providers waited for new members to contact their office for an IHA appointment. This method to ensure IHA completion is inadequate. The DHCS medical audit included a verification study of 23 medical records. Five (5) medical records identified members received IHAs beyond 120 calendar days of enrollment. These members received IHAs within 129 to 295 days. **This is a REPEAT finding.** **<u>RECOMMENDATION</u>:** **2.4.1** Ensure that new members receive an IHA within 120 calendar days of enrollment.	stakeholders in discussions about interactions to increase compliance. • Currently recruiting additional physicians as employees of the plan to complete scheduled in-home IHAs. **ONGOING OVERSIGHT:** In order to ensure that the interventions proposed and currently in place are effective, Medical Management through the Quality department will continue to keep track, real time, of the individuals in need of an IHA and the scheduled appointments.			-A snapshot of IHA completion rates for 2015. Rates reported are as follows: Q2 41.3%; Q3: 40.8%; Q4: 37.3%. Due to the low rates reported, CHG indicated outreach to the assigned PCPs of record will be conducted. 3/25/16 – Per DHCS request CHG has submitted a sample of a letter sent to a provider who was not compliant with IHA timeframe. A list of members missing IHA was enclosed. **This finding is closed.**
2.4.2 Plan Methodology to Monitor Initial Health Assessment Compliance The Plan is required to ensure the provision of an IHA in conformance with *California Code of Regulations, Title 22, § 53910. 5 (a)(1)* to each			**5/31/16**	**<u>2.4.2</u>** 2/12/16 – CHG submitted template letter dated 3/15/16 which informs providers to use specific CPT codes for New Patient (99381 – 99387)

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
new member within 120 calendar days of enrollment *[Contract, Exhibit A, Attachment 10 (3)(A)J* and to have procedures to monitor IHA completion *(MMCD Policy Letter No. 08-003 Initial Comprehensive Health Assessment)*. The Plan's method to monitor IHA completion was inadequate. The Plan conducts a Facility Site Review (FSR) every three years to monitor and ensure comprehensive medical assessment and follow-up care is rendered. The Plan reported the IHA completion rate ranging from 32% to 60% for members who must have a completed IHA within 120 calendar days of enrollment. Retrospective review of IHA completion every three years during FSRs does not constitute effective monitoring of IHA completion. The Plan's methodology to monitor IHA compliance was incomplete. Certain Current Procedural Terminology (CPT) codes were assumed to represent an IHA, but the Plan did not test the data's validity. The Plan utilizes encounter data to track and report IHA completion on a quarterly basis. This method does not compare encounter data to the medical record. **RECOMMENDATION:** **2.4.2** Ensure procedures for monitoring IHA compliance are based on validated methodology.				and established patient (99391 – 99397; 99420) to document IHA completion. 3/25/16 – Per DHCS' request to CHG to provide evidence that the CPT codes used for IHA have been validated, CHG stated in an email response, "Henceforth, CHG will fully implement a validation process wherein a statistically meaningful number of medical records will be cross checked against IHA encounter data to verify actual completion of said assessment. The validation process will be conducted monthly, beginning with encounter data from Q4 2015 and on a quarterly basis thereafter. The sample population will be derived from our high volume clinics with high rates of IHA encounter data submission." 4/1/16 – Per CHG's response, desktop procedure for monthly IHA validation process is undergoing finalization. CHG to submit finalized desktop procedure and provide samples of

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				validation by 5/31/16. DHCS will conduct follow-up. **This finding is provisionally closed.**
3. Access and Availability of Care				
3.1 APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES **3.1.1 Appointment Availability Time Frames** The Plan is required to ensure that appointments are available for routine care, specialty care, and initial prenatal care within certain time frames. [Contract, Exhibit A, Attachment 9 (3)(8) and (4)(8)] The Plan did not ensure that providers offer members appointments within the required time frames. These factors indicate providers were not in compliance with timely access requirements: • The Plan monitored appointment wait times for routine and specialty care appointments through the Industry Collaborative Effort (ICE) Appointment Availability Survey for 76 providers sampled from three delegated medical groups. The survey showed providers were unable to offer timely appointments. Among the results, 30 percent of primary care providers were unable to offer members timely routine appointments	This issue has been addressed and the following corrective actions were implemented. **RESOLUTION:** • The Customer Service, Quality, Utilization, Grievance & Appeals, and Contract managers review grievance trends related to Access to PCP and Specialty Care Providers. (A trend is more than one grievance directed at the same provider.) • This information is communicated and reviewed by the operations team. Interventions are identified during this conversation. • The Customer Service Department and Quality staff are involved in following up with the provider in question and managing corrective	3.1.1 & 3.1.2 Apt Availability Wait Times	Corrective actions have been completed.	**3.1.1** 2/12/16 – CHG submitted: -Documentation of new processes in place to more robustly track and trend access related grievances. Two codes are trended: "Access Specialty" and "Access PCP." The new process indicates that corrective actions will be taken against two or more grievances by the same provider in a given quarter. -A sample CAP for a provider which demonstrates implementation of new processes. CHG sent the provider an alert reminding him/her of the timely access standards for appointment scheduling. Secret shopper

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
within 1O business days. Additionally, 50 percent of Cardiology and Dermatology providers were unable to offer specialty appointments to members within 15 business days. • The Plan's 2014 Consumer Assessment of Health Plans Survey (CAH PS®) results showed the Plan scored at or below National Committee for Quality Assurance's 25th percentile rank in two composite measures: Getting needed care and Getting care quickly. Respondents reported they did not get an appointment for health care as soon as they thought they needed. The Plan identified these areas as opportunities to improve. • The second highest complaint was related to access issues. This finding correlates with the non-compliance rates with timely access standards. The DHCS medical audit included an appointment availability verification study. The study illustrated non-compliance with wait times to obtain appointments for routine, specialty, and prenatal care. The auditor reviewed fourteen providers from the Plan's Provider Directory. The third next available appointment was used to measure access to care. According to the *National Quality Measures Clearinghouse*, "Access is a measure of the patient's ability to seek and receive care with the	actions related to the issues identified. • Provider contracting is engaged in regular reviews of network adequacy standards. When gaps in care are identified or network providers indicate changes in availability, the operations team discusses interventions and recruiting strategies. • Policies and Procedures were reviewed and updated as needed. These policies were submitted to DHCS in September for review and are currently pending approval. **ONGOING OVERSIGHT:** Access trending data is shared with leadership regularly. The information collected to date indicates a decrease in access related grievances for both MediCal and CalMediConnect in Q3. See **Exhibit A** for the details of actions taken. There was one identified trend for Access to PCP. See **Exhibit D** for specific example. Related to Access Specialty Care, a trend was not identified this quarter. Steps normally taken to address this type of grievance are found in **Exhibit G.**			was also conducted and the provider was educated. -A graph which shows the dramatic decline of access related grievances (PCP and specialist) for 2015 (Q2, Q3, Q4). **This finding is closed.**

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
provider of their choice, at the time they choose, regardless of the reason for their visit. Counting the *third next available appointment* is the healthcare industry's standard measure of access to care and indicates how long a patient waits to be seen. This measure is used to assess the average number of days to the third next available appointment for an office visit for each clinic and/or department. This measure does not differentiate between "new" and "established" patients." The verification study found a total of five providers non-compliant with access standards. The results of the verification study are as follows:				

Provider Type	Contract Standards	Average Third Next Available Appointment
Non-urgent primary care	within ten business days of request	12.4 business days
Specialty care	within 15 business days of request	20.2 business days for new patients 19.6 business days for established patients
First prenatal visit for a pregnant member	within two weeks upon request	17.8 calendar days

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
RECOMMENDATION: **3.1.1** Ensure that members are offered appointments for routine care, specialty care, and initial prenatal care within the required time frames.				
3.1.2 Appointment Standards Publication The Plan is required to establish acceptable accessibility requirements in accordance with *California Code of Regulations, Title 28, § 1300.67.2*. This includes informing members regarding accessibility of services. *[Contract, Exhibit A, Attachment 9 (3)]* The Member Guide/Evidence of Coverage lacks the appointment standard for initial prenatal visit. The appointment standard is within two weeks upon request. This information was not available in any other sources available to members such as the Plan's website and member newsletters. **RECOMMENDATION:** **3.1.2** Update the Member Guide/Evidence of Coverage to include the standard for timely appointments for initial prenatal care of two weeks as required in the Contract.	This issue has been corrected. **RESOLUTION:** The Member Guide/Evidence of Coverage includes the standard for timely appointments for initial prenatal care. (See attached EOC).		Corrective actions were completed during the last week in June 2015.	**3.1.2** 2/12/16 – CHG submitted page 37 of the EOC which indicates that the initial pre-natal visit must be scheduled within 10 business days of the request. (NOTE: This is more stringent than the two-week requirement.) **This finding is closed.**

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
3.6 ACCESS TO PHARMACEUTICAL SERVICES **3.6.1 Emergency Pharmaceutical Services Monitoring** The Plan is required to have written policies and procedures to describe how it and/or its network hospitals will monitor compliance with ensuring member access to at least a 72-hour supply of a covered outpatient drug in an emergency situation. *[Contract, Exhibit A, Attachment 10 (B)(G)(1)(a)]* The Plan did not effectively monitor compliance to ensure member access to at least a 72-hour drug supply in an emergency situation. *Policy 7311, 24-hour Pharmacy Access*, states the Plan monitors emergency pharmaceutical services from member complaints. The Members Services Department documents member's drug supply access complaints that resulted from an emergency situation. The Member Services Department compiles and reviews pharmaceutical services complaints. The department reports findings quarterly in its Member Complaint Analysis report. The Member Services Department addresses identified issues. The Pharmacy Process was the top member complaint according to the Call Tracking Complaint Log. Although the Plan maintains policies and	This issue has been corrected. Corrective actions were completed during the last week in November 2015. **RESOLUTION:** • Case management processes pertaining to identifying member changes in condition as a result of emergency issues have been updated to include verification of the need for an emergency supply of drugs when necessary. • Member and provider education will be developed and communicated within newsletters. • Outreach to high utilized emergency service providers that fail to assist the member in accessing a 72-hour supply will occur if patterns are identified. • Policy and Procedure 7311 Twenty-Four Hour Pharmacy Access was reviewed, updated as needed and submitted to DHCS for review and approval. The policy was approved by DHCS on August 4, 2015.	3.6 ACCESS TO PHARMACEUTICAL SERVICES	Corrective actions were completed during the last week in November 2015.	**3.6.1** 2/12/16 – CHG submitted P&P 7311 which still relies only on member complaints to identify gaps with access to 72-hour supply of emergency drugs. 2/26/16 – Per DHCS' request, CHG submitted results of monitoring for access to the 72-hr emergency supply for the period 10/2/15 through 1/16/2016. 11 cases were reviewed in this audit and CHG identified follow-up activity needed for 7 cases. 3/25/16 – In response to DHCS' request asking CHG how the Plan will ensure continual monitoring in the future, the Plan stated, "[B]eginning 2nd quarter 2016, CHG will begin a daily review of a sample of cases of members who went to the ER the day before, so that they can intervene sooner to assist the member, if necessary." The Plan also attached a copy of a desktop process

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
procedures to monitor adequate supply of drugs in an emergency, it had no effective system to monitor its network hospitals' compliance of the 72-hour drug supply in an emergency situation. Sole reliance on members to report emergency pharmaceutical issues through the grievance process does not by itself constitute an effective monitoring procedure. **RECOMMENDATION:** 3.6.1 Implement an effective system to monitor network hospitals' compliance with ensuring member access to a 72-hour drug supply in an emergency situation.	**ONGOING OVERSIGHT:** In order to ensure that this information is captured and managed appropriately the interdisciplinary care team will discuss and apply interventions as needed. This information will also be reported to quality if negative trends arise.			titled, "Community Health Group – Pharmacy Department Desktop Policies & Procedures Emergency 72-Hour Drug Supply Review" which describes the monitoring process. . 4/1/16 – Per DHCS' request, CHG submitted another sample audit titled, "72 Hr ER Supply Audit" indicating that 9 cases were audited from 3/24/28-3/28/16. This demonstrates ongoing monitoring. CHG advises that the desktop procedure previously submitted will likely be updated in the future. **This finding is closed.**
4. Members' Rights				
4.1 GRIEVANCE SYSTEM **4.1.1 Grievance written acknowledgement and resolution notices were not provided to members.** The Plan is required to process grievances in accordance with C*alifornia Code of Regulations, Title 28, § 1300.68*; this includes providing a written acknowledgement and a written resolution	This issue has been corrected. Corrective actions were completed during the month of September 2015. **RESOLUTION:** **4.1.1:**	4.1 Grievance System	Corrective actions were completed during the month of September 2015.	**4.1.1** 2/26/15 – Per DHCS' follow-up request, CHG submitted a grievance log (4.1.1 B) which documents that during the timeframe of 10/01/15-12/14/15, written acknowledgement and

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
to members. *[Contract, Exhibit A, Attachment 14 (1)(A)]* Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. *[California Code of Regulations, Title 28, § 1300.68(d)(B)J* The regulation defines a complaint the same as a grievance. According to the Plan's *Policy 5510, Member Grievances and Appeals*, a grievance is a written or oral expression of dissatisfaction. Grievances are usually resolved promptly. If a grievance cannot be resolved by the close of the next business day after its receipt, also known as non-exempt grievances, written acknowledgement requirements apply. The Plan sends a written acknowledgement for all Quality of Care (QOC) and non-exempt grievances within five days. The Plan notifies the member in writing of the grievance resolution within thirty (30) days. The Plan's grievance system failed to appropriately process 189 non-exempt grievances in regards to the Plan and providers. Non-exempt grievances require the written acknowledgment notifications. The Plan did not send acknowledgement and resolution letters to members.	• Trained & Educate Customer Relations Specialists Trained Customer Relations Specialists to properly identify Grievance issues. Desktop Process "Customer Service Best Practice Guide: Complaint & Grievance Process" created (Exhibit 1). • Updated Grievance Call Types/Call Codes Aligned CHG Grievance Call Types/Call Codes to regulators classifications (Exhibit 2). • Trained & Educated Customer Relations Specialists – Trained Customer Relations Specialists to follow better practices in case documentation. Desktop Process "Customer Service Best Practice Guide: Case Documentation" created (Exhibit 4). – Trained Customer Relations Specialists on the new Quality of Care Rapid Response Process. Desktop Process "Customer Service Best Practice Guide: Quality of Care			resolution was consistently provided to members. 3/25/16 – CHG submitted P&P 5510 and a flow chart titled, "Grievance & Appeals Process" which documents that processes are in place for sending written acknowledgement and resolution to members. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
The Plan receives grievances primarily through the Member Services Call Center. Member Services Representatives review and usually resolve member grievances by the close of the next business day. Member Services Representatives forward non-exempt grievances to the Grievance and Appeals Manager to process. Grievances received by mail, the internet, or fax are processed directly by the Grievance and Appeals Manager. The Grievance and Appeals Manager logs clinical grievances as QOC grievances and all other grievances as Quality of Service (QOS) grievances. When grievances are processed by the Grievance and Appeals Manager, members receive an acknowledgement letter within five days for all QOC and QOS grievances. The Grievance and Appeals Manager consults with the Member Services Manager to resolve QOS grievances. The Plan notifies members of the resolution within thirty (30) days. The Member Services Call Center received and processed 3,552 grievances during the audit period. Our review found 189 of the 3,552 grievances were non-exempt; Member Services Representatives failed to forward these grievances. As a result, the Grievance and Appeals Manager failed to oversee these cases. Consequently, the Plan failed to monitor the proper treatment of these grievances. The Plan failed to send members a written acknowledgement or resolution notices.	Rapid Responses" created (Exhibit 5). – Trained Customer Relations Specialists on the new Quality of Care Rapid Response Process. Desktop Process "Customer Service Best Practice Guide: Quality of Service Rapid Responses" created (Exhibit 6). – All cases open beyond 48 hours are forwarded to both the Director of Quality and the Grievance and Appeals Manager and to ensure resolution of grievances within 30 calendar days. – Reviewed and updated policy 7609.1 Potential Quality Issues Investigation as needed and submitted to DHCS for review and approval in September. The policy is currently pending approval. The Policy was also submitted to the DMHC for review and received approval on December 24, 2015.			

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
A verification study sampled 21 non-exempt grievances from the Plan's Call Tracking Log 2014-2015, which included complaints regarding access to care, pharmacy process, Plan benefits, enrollment eligibility, and primary provider quality of care. The Plan failed to process these grievances according to Contract requirements associated with written acknowledgment and resolution notices. The grievance system did not allow for prompt review of grievances. The Plan did not monitor or conduct any internal audit of the Plan's Call Tracking Log to ensure that potential systemic issues and grievances were identified. The Plan was noncompliant with the grievance written acknowledgment and resolution notices. **RECOMMENDATION:** **4.1.1** Send grievance written acknowledgment letters to members within five calendar days and resolution letters within 30 calendar days.				
4.1.2 Grievance Resolution Time Frames The Plan is required to resolve each grievance and provide written notice to the member within 30 calendar days of receipt *[Contract, Exhibit A, Attachment 14 (1)(A)J*. *Policy 5510, Member Grievances and Appeals*, states the Plan notifies the member in writing of the grievance resolution within thirty (30) days. The systemic issues associated with grievances	**4.1.2:** • Trained & Educated Customer Relations Specialists Trained Customer Relations Specialists to properly identify Grievance issues. Desktop Process "Customer Service Best Practice Guide: Complaint & Grievance Process" created (Exhibit 1). • Updated Grievance Call			**4.1.2** 2/12/16 – CHG submitted: -Evidence of numerous trainings for customer service specialists regarding a variety of topics (documentation, categorization, quality of care, etc.). However, training materials do not indicate that timely resolution was addressed.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
resulted in the resolution time to exceed Contract requirements. Members were not notified of the grievance results within thirty days. The audit identified 76 grievances resolved by the Member Services Call Center exceeded 30 days; 17 ranged between 31 - 167 days to resolve and 59 had no resolution date. The Plan attributed this oversight to staff turnover. Additionally, a verification study reviewed QOC grievances and found that the Plan mailed 12 resolution letters beyond the 30 calendar day time frame. In these instances, the Grievance and Appeals Manager provided a nonspecific response within 30 days. The response excluded pertinent details specific to the grievance. The resolution signed by the Chief Medical Officer (CMO) which contained the relevant details exceeded the 30 day time frame. The Plan was not in compliance with the grievance resolution time frame requirements. **RECOMMENDATION:** **4.1.2** Resolve grievances within 30 calendar days.	Types/Call Codes Aligned CHG Grievance Call Types/Call Codes to regulators classifications (Exhibit 2). • Trained & Educated Customer Relations Specialists – Trained Customer Relations Specialists to follow better practices in case documentation. Desktop Process "Customer Service Best Practice Guide: Case Documentation" created (Exhibit 4). – Trained Customer Relations Specialists on the new Quality of Care Rapid Response Process. Desktop Process "Customer Service Best Practice Guide: Quality of Care Rapid Responses" created (Exhibit 5). – Trained Customer Relations Specialists on the new Quality of Care Rapid Response Process. Desktop Process "Customer Service Best Practice Guide: Quality of Service			-"Customer Service Auditing & Monitoring Process" (Exhibit 7). Step 6 states, "The Customer Service Manager/Auditor will identify QOC, QOS cases and any grievance case over 48 hours and daily email the Director of Quality and Grievance Manager to follow up on those cases. The CS Auditor will also put in the Resolution of the case that the grievance has been escalated to the Grievance Manager. All Grievances are emailed to the Director of Quality daily." 2/26/15 – Per DHCS' follow-up request asking for documentation to substantiate timely resolution, CHG submitted "Customer Service Daily Grievance Audit" (4.1.2 B) for January 2016. The log shows 100% compliance for timeliness of grievance resolution. However, the log appears to include exempt grievances only. This finding concerns standard grievances that are resolved beyond the 30-day timeframe.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	Rapid Responses" created (Exhibit 6). – All cases open beyond 48 hours are forwarded to both the Director of Quality and the Grievance and Appeals Manager and to ensure resolution of grievances within 30 calendar days. – Implemented a Daily Audit of all Grievance Issues. See "CS Auditing" document for process (Exhibit 7). – Implemented a Daily Audit of Determination Issues. See "CS Auditing" document for process. – Implemented a Daily Audit of a randomized sample of Inquiry Issues. See "CS Auditing" document for process. – All grievances are forwarded to the Director of Quality and the Grievance Manager on a daily basis and grievances are escalated as appropriate. See "CS Auditing" document for process (Exhibit 7). – Reviewed and updated policy 7609.1 Potential			DHCS Comments: The log submitted under 4.1.2 B appears to include exempt grievances only. Please provide documentation to substantiate that CHG is monitoring timeliness of resolution within 30 calendar days for standard (not exempt) grievances. If results show that CHG is not in compliance, please include a process for improving processing timeframes as well as a date for expected implementation. 4/12/16 – In an email response the plan stated, "CHG fully recognizes the importance of timely resolution of all grievances. In an effort to comport with the expectation, CHG has increased staffing with an additional Grievance RN. Along with the aforementioned daily review of the aging report, the Grievance Committee (led by our Chief Medical Officer) reviews the timeliness report on a weekly basis. The status of all open cases is reviewed

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	Quality Issues Investigation as needed and submitted to DHCS for review and approval in September. The policy is currently pending approval.			and escalated when indicated to ensure timely resolution." DHCS Comment: DHCS will follow-up with CHG to request samples of the daily aging and weekly timeliness reports in May 2016 to verify that timeliness of grievance resolution is being monitored for compliance and corrective action is taken if indicated. **This finding is provisionally closed.**
4.1.3 Grievance Clinical Oversight The Plan must implement and maintain procedures to ensure that the grievance submitted is reported to an appropriate level and the participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to the Plan's Medical Director. *[Contract, Exhibit A, Attachment 14 (2)(0) and (E)]* No oversight was conducted by clinical personnel to ensure proper identification of clinical/quality of care grievances. The Member Services Call Center receives member grievances. Member Services Representatives, non-clinical employees, review the grievances to classify as administrative versus	**4.1.3:** • Implemented a Daily Audit of all Grievance Issues. See "CS Auditing" document for process (Exhibit 7). • Implemented a Daily Audit of Determination Issues. See "CS Auditing" document for process. • Implemented a Daily Audit of a randomized sample of Inquiry Issues. See "CS Auditing" document for process. • All grievances are forwarded to the Director of Quality and the Grievance Manager on a daily basis and grievances are escalated as appropriate.			**4.1.3** 2/12/16 – CHG submitted: -Evidence of numerous trainings for customer service specialists including "Customer Service Best Practice Guide: Quality of Care Rapid Responses" (Exhibit 5). -P&P 7609.1 ("Potential Quality Issue Investigation and Resolution") which on page 3 states, "If the Corporate Quality Analyst initial review determines that there are no provider or system issues, the case is

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
clinical care. The Plan lacked clinical oversight and failed to monitor grievances appropriately. The Member Services Representative forwards clinical grievances to the Grievance and Appeals Manager. The Grievance and Appeals Manager logs the cases as QOC grievances. The Grievance and Appeals Manager routes the cases to the CMO via the Director of Corporate Quality (a Registered Nurse) for research and resolution. As part of the pre-audit document submission, the Plan's Call Tracking Log 2014-2015 identified 82 exempt QOC grievances processed through the Member Services Call Center. Subsequent to submission, the Plan's Director of Corporate Quality reviewed the QOC grievances and reclassified 46 grievances as QOS; 36 remained classified as QOC. The audit identified Member Services Representatives processed 36 medical quality of care exempt grievances during the audit period. As a result, the grievances were not routed to the Grievance and Appeals Manager to ensure the grievances were reported to the CMO. Consequently, the Grievance and Appeals Manager did not refer these clinical cases to the CMO for research and resolution. **This is a REPEAT finding.** **RECOMMENDATION:** **4.1.3** Develop and implement a process for monitoring and reviewing grievances designated	See "CS Auditing" document for process (Exhibit 7). • CHG has formed a Quality Care Grievance Committee where grievances related to quality are reviewed by a clinical team including the Medical Director. • All cases open beyond 48 hours are forwarded to both the Director of Quality and the Grievance and Appeals Manager and to ensure resolution of grievances within 30 calendar days. • Reviewed and updated policy 7609.1 Potential Quality Issues Investigation as needed and submitted to DHCS for review and approval in September. The policy is currently pending approval.			reviewed by the CMO." This is consistent with the contractual requirement. -"Customer Service Daily Grievance Audit" (4.1.2 B) for January 2016 which shows that all grievances were sent to the Director of Quality. However, the contract requires all grievances related to medical quality of care issues be referred to the Medical Director specifically. 4/1/16 – CHG submitted P&P 5510 ("Member Grievances and Appeals" which is consistent with the contractual requirement and on page 6 states, "All Quality of Care grievances are received and tracked by the Appeals Manager and immediately forwarded to the Chief Medical Officer, via the Director of Corporate Quality for research and resolution. The Chief Medical Officer is responsible for ensuring appropriate research and resolution." In the Plan's written email response, the Plan also

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
as administrative versus clinical to ensure quality of care issues are not missed or unresolved by the CMO.				provided clarification indicating several quality checks have been built into Plan processes including staff training that occurred with Customer Relations Specialists on how to distinguish QOC from QOS issues and the appropriate codes to use for each. The Plan states, "Our goal on a daily basis is for our Customer Service Quality Analyst to review 100% of our grievances to determine if they were appropriately classified. The analyst also reviews the audio recordings of the Quality of Care & Quality of Service grievances to help validate the proper classifications. Our process is to refer the grievances to the Corporate Quality Director who also reviews the grievances daily for proper classification. Any grievance not properly identified is flagged and appropriately categorized." **This finding is closed.**

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
4.1.4 Grievance Quarterly Reports The Plan must submit a quarterly report to the Department of Health Care Services (DHCS) describing grievances that were or are pending and unresolved for 30 days or more. *[Contract, Exhibit A, Attachment 14 (1)(A)]*, Due to the misclassifications of grievances discussed above, the Plan sent inaccurate reports to DHCS. The Plan re-filed these reports on July 15, 2015. **RECOMMENDATION:** **4.1.4** Ensure the accuracy of the grievance quarterly reports sent to DHCS.	**4.1.4:** • Trained & Educated Customer Relations Specialists Trained Customer Relations Specialists to properly identify Grievance issues. Desktop Process "Customer Service Best Practice Guide: Complaint & Grievance Process" created (Exhibit 1). • Updated Grievance Call Types/Call Codes Aligned CHG Grievance Call Types/Call Codes to regulators classifications (Exhibit 2). • Trained & Educated Customer Relations Specialists – Trained Customer Relations Specialists to follow better practices in case documentation. Desktop Process "Customer Service Best Practice Guide: Case Documentation" created (Exhibit 4). – Trained Customer Relations Specialists on the new Quality of Care Rapid Response Process. Desktop Process "Customer			**4.1.4** 2/12/16 – CHG submitted: -Evidence of numerous trainings for customer service specialists regarding a variety of topics including misclassification of grievances. -"Customer Service Auditing & Monitoring Process" (Exhibit 7)which states, "Customer Service Manager/Auditor will audit 100% of the 'Determinations' for Call Type/Code Accuracy." -Quarterly grievance reports for Q4 of 2015 was submitted on 02/15/16. DHCS Comments: Although there is no way for the DHCS to validate the accuracy of quarterly reports submitted, in light of CHG's efforts to retrain and audit customer service specialists on misclassification of grievances, this finding is deemed closed. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	Service Best Practice Guide: Quality of Care Rapid Responses" created (Exhibit 5). – Trained Customer Relations Specialists on the new Quality of Care Rapid Response Process. Desktop Process "Customer Service Best Practice Guide: Quality of Service Rapid Responses" created (Exhibit 6). – All cases open beyond 48 hours are forwarded to both the Director of Quality and the Grievance and Appeals Manager and to help ensure resolution of grievances within 30 calendar days. – Implemented a Daily Audit of all Grievance Issues – See "CS Auditing" document for process (Exhibit 7). – Implemented a Daily Audit of Determination Issues – See "CS Auditing" document for process. – Implemented a Daily			

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	Audit of a randomized sample of Inquiry Issues. See “CS Auditing” document for process. – All grievances are forwarded to the Director of Quality and the Grievance Manager on a daily basis. See “CS Auditing” document for process (Exhibit 7). • Reviewed and updated policy 7609.1 Potential Quality Issues Investigation as needed and submitted to DHCS for review and approval in September. The policy is currently pending approval. • All of the above actions will help ensure that the quarterly reports are accurate. **ONGOING OVERSIGHT:** The Customer Service Manager reviews 100% of Grievances daily. All grievances are closed within 48 hours. If it is determined that the grievance can’t be resolved within 48 hours the grievance is escalated to the Grievance and Appeals Manager immediately.			

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
4.2 CULTURAL AND LINGUISTIC SERVICES **4.2.1 Linguistic Capability of Interpreters** The Plan shall implement and maintain a written description of its Cultural and Linguistic Services Program, which shall include qualifications of staff. *[Contract, Exhibit A, Attachment 9 (13)(A)J* The Plan has a process to assess, identify, and track the linguistic capability of interpreters. However, the method to measure proficiency and monitor linguistic capability is not described in the Plan's policies and procedures. According to the Plan, approximately 70% of Plan staff are bilingual and adequately proficient to provide translation and interpretation services. Staff language proficiency is self-reported. In employment interviews, the Plan internally evaluates conversational and/or medical terminology proficiency. For specific translators, the Plan administers the Berlitz language test to measure proficiency in speaking, listening, reading, and writing a language. However, the Plan does not have a policy that includes these procedures. **<u>RECOMMENDATIONS:</u>** **4.2.1** Update the Plan's policies and procedures to include the Plan's process to assess, identify, and track the linguistic capability of interpreters.	This issue has been corrected. Per our P&P "7400 Language Assistance Program" all of Community Health Group's Customer Service Staff members are bilingual in either Spanish, Vietnamese or Arabic. Every Customer Relations Specialist has completed a second language proficiency certification through Berlitz. A Language Line Solution is in place to provide interpreter services for more than 140 languages, 24 hours a day, 7 days a week. A proficiency certification is provided to all internal staff and as a part of vendor management the assessments completed are verified for external interpreters. They follow a structured multi-step quality assurance for their interpreters initiated at recruitment level which includes a Language Proficiency Test, a six component interpreter skills assessment, up to 80 hours of training, and for healthcare interpreters. Each interpreter is monitored and coached by a Senior Language Specialist approximately once per month. Additionally, Community Health Group contracts with Alliance for African Assistance to provide face to	4.2 Cultural Linguistic Services	This issue has been corrected.	**<u>4.2.1</u>** 2/12/16 – CHG revised P&P 7400 ("Language Assistance Program") to incorporate language on how the Plan assesses the linguistic capability of both in-house and contracted interpreters. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	face interpretation. They utilize several Quality Assurance Mechanisms which include, daily monitoring of activities, customer satisfaction surveys for each service provided, 40 hours minimum of interpreter training, medical terminology training, and 90% grade or above requirement on an internal exam aimed at testing interpreting ethics, professionalism, English knowledge, medical terminology, HIPAA/HITECH, and colloquialisms/slang. **RESOLUTION:** Updated the policy and procedure to reflect how the plan currently assess interpreter capabilities. The policy was submitted to DHCS for review and approval September 9, 2015. DHCS approved this policy on October 12, 2015. **ONGOING OVERSIGHT:** • Compliance will monitor this activity through regular reports provided by Customer Service. • Documentation is maintained in employee records, when necessary, pertaining to language proficiency. • Annual reviews of vendor practices has been added to			

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	compliance audit.			
4.3 CONFIDENTIALITY RIGHTS **4.3.1 Breach Incident Reporting** Upon discovery of any breach or security incident, the Plan is required to notify the Department of Health Care Services (DHCS) Privacy Officer, the Managed Care Operations Division (MCOD) Contracting Officer, and the DHCS Information Security Officer. *[Contract, Exhibit G, Attachment 3 (H)]* During the audit period, six (6) breach cases were reported only to the DHCS Privacy Officer within the required time frame but not to the MCOD Contracting Officer and the DHCS Information Security Officer. **This is a REPEAT finding.** **RECOMMENDATIONS:** 4,3,1 Notify and report breach incidents to the DHCS Privacy Officer, MCOD Contracting Officer, and the DHCS Information Security Officer.	This issue has been corrected. **RESOLUTION:** • The staff assigned to the reporting process has been retrained. • The tracking tool used to manage the privacy cases has been enhanced to capture the time frames associated with reporting the information to the three offices. **ONGOING OVERSIGHT:** In order to ensure that this issue does not occur again Compliance will add this activity to the high risk processes for 2016. Compliance will report the communication steps to the compliance committee and leadership when privacy issues are identified.	4.3 Confidentiality Rights	This issue has been corrected.	**4.3.1** 2/12/16 – CHG revised and submitted P&P 5500 ("Policy on Breach Notification") to include required notification to the MCOD Contracting Officer and the DHCS Information Security Officer. 3/25/16 – Per DHCS request, CHG submitted a log of breaches from 4/16/15 through 1/7/16. It was noted that all of these breaches were reported to the three agencies properly. Also, CHG has attached emails substantiating reporting to all three agencies. **This finding is closed.**
5. Quality Management				

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
5.2 PROVIDER QUALTIIFCATIONS **5.2.1 Provider Training Completion** The Plan must ensure that all providers receive training. *[Contract, Exhibit A, Attachment 7, (5)]* The Plan did not conduct provider training for all providers. The review found six new providers did not receive training as required by the Contract. The providers were part of an existing physicians group currently active in the network. The Plan does not have any follow-up procedures in place to ensure new providers added to an existing network provider group have received training. The Plan stated these providers only received a welcome letter with a username and password to access the Plan's provider manual and information online. This did not constitute training. The Plan was responsible for all new provider training. **RECOMMENDATION:** 5.2.1 Ensure that all providers receive training.	This issue has been corrected. Corrective actions were completed during the month of September. Providers receive a New Provider Orientation Training (see Exhibit 8) within 10 working days after being placed on active status. Currently, they receive a link with the training material in their paperwork. We also do a second onsite training with the new providers and make every effort to do it within 10 working days. In some cases, the provider is unable to meet within the first 10 days. **RESOLUTION:** • Developed a process to include training within 10 days to all newly contracted providers. • Improved the formal communication between provider contracting and Provider Relations to ensure that newly contracted providers receive the outreach needed to complete training. • Improved the process for Provider Relations staff to reach out to providers via e-	5.2 Provider Qualifications	This issue has been corrected.	**5.2.1** 2/12/16 – CHG submitted: -PowerPoint training for new providers. -P&P 5101 (“New Practitioner Orientation”) which requires the Plan to conduct training within 10 working days for new providers. -Spreadsheet which shows how the Plan tracks timely completion of training. 4 of 4 new providers were documented as having received training within the required timeframe in February and March 2016. -“10-Day Provider Training – Provider Relations; E-Signature” workflow document which was implemented on 12/27/15. Document describes how the Provider Relations coordinates with the Contracting Department to ensure timely completion of training.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	mail and face to face, where necessary, in order to complete the review of the training and orientation materials. • In the process of developing a process to ensure to capture an electronic signature associated with training offered online. • Updated the new contract set up dashboard to include capturing information pertaining to provider training. **ONGOING OVERSIGHT:** In order to ensure that this issue does not occur again, operations senior leadership and compliance will track the completion of new provider training utilizing contract set up dashboard.			**This finding is closed.**
5.2.2 Provider Training Time Frame The Plan is required to conduct training for all newly contracted providers within 10 working days after they are placed on active status. *[Contract, Exhibit A, Attachment 7, (5)]* The Plan did not complete new provider training timely. During the audit period, two providers received training beyond the 10 working day time frame. They received training 11 and 22 days after they were placed on active status.				**5.2.2** 2/12/16 – CHG submitted: -PowerPoint training for new providers. -P&P 5101 (“New Practitioner Orientation”) which requires the Plan to conduct training within 10 working days for new providers.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
RECOMMENDATION: 5.2.2 Ensure that all new providers are trained within 10 working days after being placed on active status.				-Spreadsheet which shows how the Plan tracks timely completion of training. 4 of 4 new providers were documented as having received training within the required timeframe in February and March 2016. -"10-Day Provider Training – Provider Relations; E-Signature" workflow document which was implemented on 12/27/15. Document describes how the Provider Relations coordinates with the Contracting Department to ensure timely completion of training. **This finding is closed.**
6. Administrative and Organizational Capacity				
6.3 FRAUD AND ABUSE **6.3.1 Fraud and Abuse Policy** The Plan is required to establish an Anti-Fraud and Abuse Program that will establish policies and procedures for identifying, investigating, and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program. *[Contract, Exhibit E,*	**6.3.1** This issue has been corrected. Corrective actions were completed during the month of September 2015. **RESOLUTION:**	6.3 Fraud and Abuse	This issue has been corrected.	**6.3.1** 2/12/16 – CHG submitted an updated but not finalized copy of P&P 5509.2 ("Managing Incidents of Suspected Fraud") which addresses the 10 working day reporting timeframe.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
Attachment 2 (25)(8)(1)] The Plan's policies and procedures, Managing Incidents of Suspected Fraud and Corrective Action Policy, excluded the 10 day reporting time frame requirements. Additionally, the Corrective Action Policy omitted the requirement to confirm suspended providers no longer receive Medi-Cal payments. The Plan established guidelines for investigating and reporting suspected fraud. The Plan revised Policy 5509.2, Managing Incidents of Suspected Fraud, as part of its corrective action plan (CAP) for the previous audit findings. The revision reflected the 10 working day reporting time frame to DHCS. (Revision Approval by Managed Care Quality and Monitoring Division (MCQMD) Date: March 2013). The Plan stated the 10 working day reporting time frame to DHCS is reflected in the Medi-Cal Compliance Plan. However, the policy's latest version excludes this language. **This is a REPEAT finding.** The Plan's *Policy 7701, Corrective Action Policy*, states that the Plan shall terminate the participation of a suspended or excluded provider. However, the policy excluded language to report the termination within 1O state working days to the Medi-Cal Managed Care Program/Program Integrity Unit and for the Plan to confirm that the provider is no longer receiving payments in connection with the Medicaid program. The audit did not find any evidence that these	• Updated the written policy and procedure to reflect the 10 working day report/communication to the State. • Added this activity to the ongoing monthly monitoring plan for the Compliance Committee. • This metric will be added to the Compliance Dashboard as well. **ONGOING OVERSIGHT:** In order to ensure that this issue does not occur again the Compliance Committee will receive specific reports pertaining to reporting/communication timeframes. Senior leadership will also review the Compliance dashboard with the metrics outlined.			DHCS Comments: Please provide a finalized and signed copy of P&P 5509.2. 3/2/016 – CHG submitted the finalized and signed copy of P&P 5509.2. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
omissions resulted in the Plan to considerably exceed the time frame or allow suspended providers to receive Medi-Cal payments. **RECOMMENDATIONS:** **6.3.1** Update the Plan's policies and procedures to include language for the 10 working day time frame and the requirement for the Plan to confirm suspended providers no longer receive Medi-Cal payments.				
6.3.2 Fraud and Abuse Reporting Time Frame The Plan is required to report to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date it first becomes aware of, or is on notice of, such activity. *[Contract, Exhibit E, Attachment 2 (25)(8)(4)]* The Plan failed to report a suspected fraud and abuse case to DHCS within the required time frame. During the audit period, the Plan reported four fraud and abuse cases to DHCS. The Plan reported one case beyond the 10 working day time frame; the Plan reported it 14 working days from the incident date. **RECOMMENDATIONS:** **6.3.2** Ensure fraud cases are reported to DHCS within the required 10 working day time frame.	**6.3.2** This issue has been corrected. **RESOLUTION:** • Updated the written policy and procedure to reflect the 10 working day report/communication to the State. The policy was submitted to DHCS for review on November 18, 2015 and is currently pending approval. • Added this activity to the ongoing monthly monitoring plan for the Compliance Committee. • This metric will be added to the Compliance Dashboard as well. **ONGOING OVERSIGHT:** In order to ensure that this issue does not occur again the Compliance			**6.3.2** 2/12/16 – CHG submitted an updated but not finalized copy of P&P 5509.2 ("Managing Incidents of Suspected Fraud") which addresses the 10 working day reporting timeframe. DHCS Comments: Please provide a finalized and signed copy of P&P 5509.2. 3/2/16 – CHG submitted the finalized and signed copy of P&P 5509.2. 3/22/16 – DHCS reviewed all six fraud cases submitted by CHG from August 2015 to February 2016. All cases were reported within the required timeframe.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	Committee will receive specific reports pertaining to reporting/communication timeframes. Senior leadership will also review the Compliance dashboard with the metrics outlined.			**This finding is closed.**

Submitted by: Norma Diaz
Title: Chief Executive Officer

Date: 02/11/2016