

**ATTACHMENT A
Corrective Action Plan Response Form**

Plan Name: Contra Costa Health Plan

Review/Audit Type: Medical Audit

Review Period: March 1, 2014 through February 28, 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
Category 1 - Utilization Management				
1.1- Improve the mechanism to monitor under and over-utilization of services by resolving the challenges of uploading and removing unnecessary data to	The Department cited that “during the onsite interview” the plan discussed challenges of updating and removing unnecessary data to produce reports, and seemingly this finding was based solely on that discussion. In discussions over the preliminary	1.1.1 Over Under Utilization Reports 10-09-2015	Done 10-09-2015	CCHP verified Over/Under Utilization Reports dated 10/09/15 are accurate reports for trending and analysis of UM Data. This deficiency is closed.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
produce accurate reports for trending and analysis of UM Data.	report, the plan identified that these problems were in the past and produced samples of over/underutilization reporting. This was not considered and the same finding appears in this final report and subject to this CAP. CCHP is again submitting its over and under utilization data, including charts etc...			
1.2- Adhere to the required time frames to ensure processing of routine prior authorization requests for medical services are met.	<p>The impact and efficiency of the Utilization Management Program (UMP) is monitored through the collection of information about the UM process. An electronic database tracks the following UM processes (Turnaround, etc). This information is tracked continually and tabulated monthly. The data provides valuable information, which includes individual provider trends, frequency of authorized procedures that perhaps should not require prior authorization, and services that may be over and underutilized</p> <p>On no less than a quarterly basis, as part of interrater reliability or in conjunction with oversight audit activities, the UM Director or Clerical Supervisor will randomly sample the work quality of the Authorization and Utilization Management department.</p>	1.2 UM 15.006 Tracking Utilization Management Systems	Done 12.15.2015	<p>The MCP submitted “P&P” UM 15.006 unsigned and undated. DHCS acknowledges that this P&P submitted indicates that the MCP shall maintain a system to monitor and track service requests that are authorized, modified, and denied as well as referrals to in-network and out-of-network providers.</p> <p>This deficiency remains open. To achieve compliance, the MCP must submit:</p> <ul style="list-style-type: none"> • A signed & dated “P&P of UM15.006 • An example demonstrating its operational use. <p>1/25/16 – MCP submitted signed and dated P&P UM15.006 and Authorization Turnaround Time Statistics for 2015 which verifies that the MCP tracks and trends service requests that are authorized, modified and denied as well as referrals to in-network and out-of-network providers to ensure that members are receiving requested services that are medically necessary.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
<p>1.4- Revise Policy and Procedure MS8.018 to adhere to the Contract and ensure the person making the final decision for the proposed resolution of an appeal/grievance has not participated in any prior decisions related to the appeal/grievance.</p>	<p>As previously discussed during negotiations around the preliminary report, CCHP always has a medical provider, who is not associated with a member appeal, make any final decision along with full Appeals Committee, to uphold a denial or partially uphold the denial that was appealed. The confusion about this may be in our process of investigation of appeals where the appeal and any new medical information supplied to the Health Plan is presented to the denying Physician to review new clinical information and if the denial can be fully overturned. This is called Rapid Review Process. IF the original denying physician cannot fully overturn the denial during Rapid Review, then the appeal goes to the Appeals Committee staff with another provider to make final decision</p> <p>We have made necessary changes to MS8.018. This policy has been approved by DHCS.</p>	<p>1.1.4 MS 8.01 Medi-Cal appeals 11.2015</p>	<p>Done 11.18.2015</p>	<p>This deficiency is closed. The MCP submitted a revised unsigned and undated “P&P” MS 8.018. In reviewing the language formatted/highlighted on page 4 of 10. Department of Health Services is asking the MCP to remove the word “new” from the sentence.</p> <p>This deficiency remains open. To achieve compliance, the MCP must submit:</p> <ul style="list-style-type: none"> • Remove the word “New” from Page 4 of 10 under formatted/ highlighted. • A signed and dated “P&P” of MS 8.018. <p>1/25/16 – MCP submitted re-revised signed and dated P&P MS 8.018.</p> <p>This deficiency is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
<p>1.5- Ensure annual oversight evaluations are conducted on the Plan's PBM.</p>	<p>The DHCS Audit Report states: "During the onsite interview, the plan stated that some of their UM functions are delegated to the pharmacy benefit management company (PBM). However, there was no documentation to support that an annual oversight evaluation of the PBM occurred during the audit period." CCHP has modified QM Policy QM14.301 to reflect that UM function is delegated only in the following areas: claims processing, credentialing (of network pharmacies), and <u>partial</u> routine UM documentation (prior authorization processing of <u>approvals only, not denials</u>). Additionally, CCHP yearly audit functions will be performed as follows:</p> <p>The Pharmacy Director or delegated individual will:</p> <ul style="list-style-type: none"> ○ Continue to collaborate with utilization management team to improve quality metrics at the plan level. ○ On a yearly basis: <ul style="list-style-type: none"> ● Assure that a third party audit of the PBM occurs – CCHP is currently in contract negotiations with S/T Health Group, a third party audit group. The contract 	<p>1.1.5 UM PBM Oversight CAP 2015</p> <p>1.1.5 QM14.301_Delegation Oversight Process RevDec2015</p> <p>1.1.5 2015 PBM audit</p>	<p>Done 12/11/2015</p>	<p>The MCP submitted their 2015 Annual PBM Audit of Perform Rx Report of Findings. This audit concluded that within the scope of work performed and review of the policies and procedures, the audit did not identify any discrepancies with PerformRx and their provision of contracted services on behalf of the MCP. Also submitted was an unsigned and undated "P&P" of QM14.301.</p> <p>This deficiency remains open.</p> <p>To achieve compliance, the MCP must submit:</p> <ul style="list-style-type: none"> ● A signed and dated "P&P" of QM14.301. <p>1/25/16 - The MCP submitted a signed and dated P&P QM14.301.</p> <p>This deficiency is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>is being finalized with county counsel, and the audit is anticipated to begin in early 2016 (and will repeat yearly thereafter).</p> <ul style="list-style-type: none"> • Perform a yearly self-audit of the PBM which will include a comprehensive review of general operations, policies and procedures, and overall evaluation of UM/QM functions. • Document yearly audit results on pharmacy shared drive, and immediately follow up with any issues discovered during the review. <p>The pharmacy director will accomplish current calendar year audit, and will continue with monitoring program thereafter on a yearly basis to measure ongoing compliance.</p>			
Category 2 – Case Management and Coordination of Care				
2.4- Improve the monitoring system to ensure IHAs are fully completed within 120 calendar days of enrollment.	CCHP was using codes provided by the State to identify IHA completion, but the audit found that those codes were not reliable. CCHP met with other Medi-Cal plans and found that several were successfully using one plan’s list of codes instead. CCHP will use those codes to create a new	Code list attached.	Such report requests typically take about six weeks. Completion expected by 12/31/15.	1/4/16 – Followed up with MCP. Completion date of Monitoring report was 12/31/15. Per MCP: It isn't ready. We stopped the request because a sister plan said they were finalizing a list of codes that would be more accurate. They said they expect the list 01/2016. 2/8/16 – Followed up with MCP, MCP received codes on 02/05/16, and new monitoring report expected

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>monitoring report. We will also audit charts while doing HEDIS review to ensure complete IHAs were done where these codes were used. CCHP will also add another mailing to further remind members to get into care and have their IHA.</p>			<p>completion date of 03/08/16.</p> <p>This deficiency is provisionally closed.</p> <p>In order to achieve compliance the MCP must submit</p> <ul style="list-style-type: none"> • new monitoring report once finalized
Category 3 – Access and Availability of Care				
<p>3.1- Improve monitoring systems to ensure the first prenatal visit for pregnant members is available within two weeks upon request.</p>	<p>We generate a monthly list of new members who are pregnant. We attempt to contact each woman. We ask whether she encountered any difficulties in getting an appointment within two weeks. We have not seen any problems getting an appointment within two weeks since we began calling.</p>	<p>Spreadsheet attached</p>	<p>In place since June 2015.</p>	<p>The MCP submitted a spreadsheet that contains a listing of newly pregnant members that were contacted by phone on 3 separate occasions. The purpose of these calls is to determine if members are receiving their first prenatal appointments within 2 weeks upon request.</p> <p>This deficiency is closed.</p>
<p>3.3- Ensure the Plan complies with the telephone answer time and abandonment rate access standards.</p>	<p>CCHP Advice Nurse Unit will continue working on meeting the telephone answer time and abandonment rate access standards. Both standards are part of our unit goals for the 2015 CCHP Advice Nurse Unit Work Plan and our Quality Improvement Project</p>		<p>June 2016</p>	<p>In reviewing Q3 of 2015 CCHP has already improved the telephone answer time and abandonment rate. Wait time was 19 seconds and abandonment rate was 0.2%.</p> <p>This deficiency is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
<p>3.5- Ensure emergency room claims incorrectly sent to the Plan are redirected to the appropriate capitated provider within 10 working days of receipt of the claim.</p>	<p>Policy number CLM 4.536 has been updated to CLM 4.536e and provides an improved process for receiving, entering, forwarding and reporting of claims requiring forwarding to our delegated entity. This process requires a change to programming from our claims scanning company. Instructions for their services and process for this procedure have been given.</p>	<p>Policy CLM 4.536e attached</p> <p>Instructions to vendor for new procedures attached</p>	<p>Expected implementation of new procedures: January 2016</p>	<p>The MCP submitted two documents:</p> <p>P&P CLM 4.536e outlining if a claim is sent to CCHP and a member is enrolled in any KSR or KAISER CCHP plan it is the responsibility of CCHP to direct the claims accordingly to Kaiser for processing.</p> <p>Instructions to vendor for new procedures</p> <p>1/14/16 – Per MCP new procedures will not be met by January 2016 due to competing priorities and complications in programming. MCP believes this should be tested by 2/15/16 and in application by 3/1/16.</p> <p>This deficiency is provisionally closed. (Expected completion date 3/1/16)</p> <p>In order to achieve compliance, the MCP must submit:</p> <ul style="list-style-type: none"> • Evidence that the completion of programming and in application has taken place.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
<p>3.6- 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.</p>	<p>The DHCS Audit Report states: “The plan did not monitor emergency departments at contracted hospitals to ensure that 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.” CCHP must ensure that pharmacy policy PM6.010 is fully enforced, including the provision pertaining to random selection and review of emergency department claims to determine if prescribed medications were dispensed in sufficient quantities. The Pharmacy Director or delegated individual will:</p> <ul style="list-style-type: none"> ○ On a quarterly basis: <ul style="list-style-type: none"> ● Run/request and review reports of emergency department medication grievances/issues through member services and quality management. ● Run/request and review report of emergency department claims that reported ‘take home medications’ versus paid pharmacy claims. Pharmacy will select and review random claims to determine if medications were dispensed in sufficient quantities to comply 	<p>3.3.6 Quarterly Emergency Department Medication Dispense Audit Q3 2015</p> <p>3.3.6 Quarterly Emergency Department Medication Dispense Audit TEMPLATE</p> <p>3.3.6 ED Emergency Supply CAP 2015</p>	<p>Done 12/11/2015</p>	<p>The MCP submitted their Q3 2015 Emergency Department Medication Dispense Audit Report. This report demonstrates that Member services grievance report is reviewed, quality management grievance report is reviewed and the emergency department claim report is reviewed and randomly audited. The Pharmacy Director will continue monitoring program and thereafter on a quarterly basis to measure ongoing compliance.</p> <p>This deficiency is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>with CCHP policy and DHCS guidance.</p> <ul style="list-style-type: none"> Document quarterly review results on pharmacy shared drive, and immediately follow up with any issues discovered during the review. <p>The pharmacy director will accomplish current audit, and will continue with monitoring program thereafter on a quarterly basis to measure ongoing compliance.</p>			
Category 4 – Member’s Rights				
4.1- Improve monitoring systems to ensure that grievances are resolved within 30 calendar days.	By far the largest proportion of late grievances were due to delays in the CCRMC system. We issued them request for corrective action, and they created a draft that we have attached. We told them the draft was not specific enough and asked for a better version, but we have not yet received it.	CCRMC improvement plan attached	Revised document expected 12/18/2015	<p>The MCP submitted signed and dated P&P 616-A. The P&P contains detailed steps for accurately identifying procedures to ensure that grievances are resolved within 30 calendar days.</p> <p>This deficiency is closed.</p>
Category 5 – Quality Management				
5.3-Ensure there is an annual delegation audit report for the PBM.	The DHCS Audit Report states: “During the onsite interview, CCHP stated that it delegates quality management functions to the pharmacy benefit management company (PBM). However, there was no annual delegation audit report	5.5.3 Quality PBM Oversight CAP 2015 5.5.3 QM14.301_Delegati on Oversight Process	Done 12/11/2015	The MCP submitted the 2015 Annual PBM Audit of Perform Rx Report of Findings. This audit concluded that the scope of work performed and reviewed of the policies and procedures, the audit did not identify any discrepancies with PerformRx and their provision of contracted services on behalf of

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>found for the PBM during the audit period.” CCHP has modified QM Policy QM14.301 to reflect that QM function is not delegated to the PBM. Additionally, CCHP yearly audit functions will be performed as follows:</p> <p>The Pharmacy Director or delegated individual will:</p> <ul style="list-style-type: none"> ○ Continue to collaborate with quality management team to improve quality metrics at the plan level. ○ On a yearly basis: <ul style="list-style-type: none"> ● Assure that a third party audit of the PBM occurs – CCHP is currently in contract negotiations with S/T Health Group, a third party audit group. The contract is being finalized with county counsel, and the audit is anticipated to begin in early 2016 (and will repeat yearly thereafter). ● Perform a yearly self-audit of the PBM which will include a comprehensive review of general operations, policies and procedures, and overall evaluation of UM/QM functions. ● Document yearly audit results on pharmacy shared drive, and 	<p>RevDec2015</p> <p>5.5.3 2015 PBM audit</p>		<p>CCHP.</p> <p>This deficiency is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>immediately follow up with any issues discovered during the review.</p> <p>The pharmacy director will accomplish current calendar year audit, and will continue with monitoring program thereafter on a yearly basis to measure ongoing compliance.</p>			

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS				
<p>Revise policies and procedures to comply with the Contract and remove language that places limitations or conditions for members to receive abortion services.</p>	<p>CCHP does not agree that this is a repeat finding. In the CAP for the audit from 2013, DHCS acknowledged that :</p> <p><u>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.</u> <u>This item is closed.</u></p> <p>The claims policy reviewed in this audit was the same policy with the same language previously approved. In the current audit it is stated that the policy is now unclear whether PA is required for “non contracted network providers.” If a provider is non-contracted, they are not in our network. However, since this is being called to question, we are clarifying in CLM4.573e to state what happens in the event the member wants to use a non-contracted provider not in CCHP’s network. In that event, the non-contracted provider must still be a Medi-Cal provider.</p>	<p>Updated CCHP Policy CLM 4.573e attached</p>		<p>The MCP has submitted revised, signed and dated P&P CLM 4.573e. It acknowledges that every Medi-Cal member is assured the freedom to choose a qualified family planning provider both within and outside our network of providers and no authorization is required.</p> <p>This deficiency is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
Ensure the Plan includes within their billing system all State Supported Service codes required by Contract.	Any missing or updated codes have been added to our procedure and to our claims system. We recognize that many of the codes listed in the contract have been changed or have become obsolete. We have tried to add other codes and similar codes in their place. Receiving regular updates of changes to codes from DHCS that could affect our contract or during Audits would be helpful to the Plan.	Updated CCHP Policy CLM 4.573e attached		The MCP has submitted revised, signed and dated P&P CLM 4.573e. This deficiency is closed

Submitted by:
Title:

Date:

Patricia A. Tanquary

SUBMITTED BY: PATRICIA TANQUARY, MSSW MPH, PhD
TITLE: CHIEF EXECUTIVE OFFICER, CONTRA COSTA HEALTH PLAN

DATE: FEBRUARY 11, 2016