



ATTACHMENT A Corrective Action Plan Response Form

Plan Name: Gold Coast Health Plan

Review/Audit Type: Medical Audit

Review Period: December 1, 2013 through November 31, 2014

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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				
1.2.1 Medical Prior Authorizations lacked a Notice of Action letter	Gold Coast Health Plan converted to a new medical management system December 2013. Cases with missing NOA letters were from early in the conversion period while staff was learning a new medical management system. Gold Coast Health Plan has completed the following: On-going training has been provided to staff, Job Aide Manuals have been reviewed and revised, and monthly staff audits are performed verifying NOA letters are sent to the appropriate parties.	-10 Samples of NOA Letter for pharmacy and medical -Copy of UM Correspondence Report -RxNOA_2015-11-02_new	Completed	The MCP has submitted their Oct UM Correspondence Report and 10 samples of NOA letter for pharmacy and medical. The MCP also instituted a new medical management system with staff training. These finding are closed.

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	As requested 10 Medical and 10 RX NOA samples are attached.			
<p>1.4.1 The Plan's policy didn't include language that would mandate written information be provided to Members at a sixth grade reading level or as determined appropriately through the Plan's group needs assessment and approved by Department of Health Care Services.</p> <p>1.4.2 The Plan didn't verify that resolution letters are at the appropriate literacy level.</p>	<p>Updated Policy #GA-002 Member Appeal Process</p> <p>a. Policy Attached with new verbiage</p> <p>Verify that resolution letters are at the appropriate literacy level</p> <p>a. Appeal Letters are reviewed by the Medical Director for final approval and verification of literacy level.</p> <p>b. 10 Samples attached of Appeal Resolution Letters</p> <p><u>Attachment:</u> Policy GA-002 Member Grievance and Appeals Process</p> <p>G&A sample File review</p>	<p>-Policy GA-002 Member Grievance and Appeals Process</p> <p>-G&A sample File review</p>	<p>Completed</p>	<p>The MCP submitted its updated GA-002 Member Appeal Process. This policy includes a provision for written information to be provided at the correct level. Submitted resolution letters were found to be at the appropriate reading level as approved by DHCS.</p> <p>These finding are closed.</p>
Category 2 – Case Management and Coordination of Care				

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<p>2.1.1 The Plan was lacking documentation for monitoring and tracking members who receive coordination of care services.</p> <p>2.1.2 The Plan's system for continuity of Care for Members with their Primary Care Providers was lacking evidence of an effective process.</p>	<p>Authorization no claims report analysis summary- This report matches OON and OOA specialist claims to authorizations to identify members who are missing appointments. Currently a RN is reviewing this report and completing the following:</p> <ul style="list-style-type: none"> • Determining if the service was rendered • Notifying the ordering provider of missed appointment • Referring to CM if CM need is identified <p>FY 2014 the count of authorizations without claims represented 0.76% of the total number of authorizations. In Q4 2014 there were a total of 97 authorizations that were identified as being unmatched to claims. Through RN research it was determined that the member received services for 35% of the authorizations that did not have a claim match. Of the remaining 65%, the RN found the following information through provider follow-up:</p> <ul style="list-style-type: none"> • The procedure was not completed but the patient is actively being followed by the 	<p>-2.1.1-2.1.2 AUTHS_NO_CLAIMS_12 04 2015.2</p> <p>- 2.1.1-2.1.2 Tracking and Monitoring of Referrals from PCP to Specialists</p> <p>- Care Management Referral Tool</p>	<p>7/15/2016</p>	<p>This item was addressed to the satisfaction of the Managed Care Quality and Monitoring Division in the previous CAP submission. The plan is in compliance with the requirements. However, the audit did uncover areas which can be strengthened. MCP has submitted the proposed system to ensure that all areas of concern to the beneficiary are address.</p> <p>The MCP has provided an explanation of how Coordination of Care process is done. The MCP developed the following; "Ordering provider notifying of missed appointment". Provider specific information will be trended to identify patterns. Corrective action plans will be issued as needed for providers who have an unusually high number of "no show" appointments."</p> <p>In order to close the deficiencies, please submit evidence of the operationalization of an updated process to track accessibility and Coordination of Care between the Primary Care Providers and Specialists, both within and outside the network.</p> <p>Deficiencies remain open</p> <p>1/22/16</p> <p>MCP submitted description of the</p>

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	<p>ordering provider</p> <ul style="list-style-type: none"> • The member missed the appointment and the provider has re-requested the service • The procedure was canceled and no longer needed • Member no showed to the appointment and cannot be reached (1 member) • Non-urgent procedure and provider was notified (2 members) <p>Conclusion: RN follow-up resulted in minimal member impact. Only 4 CM referrals were generated and of those 2 were open to CM. Providers are generally aware and managing the members. GCHP Recommendation: GCHP generate a letter to ordering provider notifying of missed appointment. Provider specific information will be trended to identify patterns. Corrective action plans will be issued as needed for providers who have an unusually high number of “no show” appointments.</p>			<p>processes to be implemented in 2016 to address the need for monitoring and tracking system to ensure accessibility and Coordination of Care between PCP and specialists.</p> <p>MCQMD finds that the proposed system will track and monitor coordination of care when fully implemented. In order to close deficiency, please submit the evidence of implementation of the monitoring and tracking Coordination of Care between PCPs and specialists:</p> <p>The date of full compliance is expected to be achieved in Q3.</p> <p>These findings are provisionally closed.</p>

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<p>2.2.1 The Plan didn't verify that all CCS-eligible Members are monitored and tracked for Case Management and that Coordination of Care between Primary Care Providers and specialty providers occur and is documented</p>	<p>Gold Coast Health Plan (GCHP) enjoys a very close and collaborative relationship to the Ventura County Public Health (VCPH) CCS program. Our partnership with CCS, as exemplified during the pre-audit, onsite and post audit, is robust and the Plan is always looking for opportunities to collaborate for the benefit of our members and providers.</p> <p>During our August 2015 Collaborative meeting, CCS explained that The California Department of Health Care Services (DHCS) has adopted the Whole Person model for their waiver for federal Medicaid funds and specified a Whole-Child Model system. The system is a model of coordinated care which starts with the primary care provider. Currently Ventura County CCS has over 3700 clients many are also GHCP members. Both the Plan and CCS felt that we have an opportunity to support the whole child model by assuring a common physician is identified as the medical home (CCS terminology) and the primary care provider (GCHP terminology).</p> <p>With all in agreement, it was decided to charter a small process improvement team. VCPH offered to provide a Six Sigma facilitator and</p>	<p>-2.2.1 CCS November 2015</p> <p>- CCS Workflow JAM</p> <p>- HS-039 California Children's Services Coordination</p> <p>- Updated HS-039 California Children's Service Coordination</p>	<p>Completed</p>	<p>This item was addressed to the satisfaction of the Managed Care Quality and Monitoring Division in the previous CAP submission. The plan is in compliance with the requirements. However, the audit did uncover areas which can be strengthened.</p> <p>The MCP has provided an explanation of GCHP and CCS working together.</p> <p>In order to close this element, please submit a plan to monitor and track case management and coordination of care for members.</p> <p>The MCP may submit its updated P&P Job Aid Manual (JAM) to show that Members with CCS-eligible conditions are referred in a timely manner to the CCS program, continue to provide medically necessary covered services not authorized by CCS and document Coordination of Care and Case Management between the Member's Primary Care Providers, CCS specialty providers, and the local CCS program.</p> <p>This element remains open.</p> <p>1/22/16 The MCP submitted updated P&P HS-039, Job Aid Manual and CCS notification report to ensure that Case management and Coordination of Care between PCP and CCS providers</p>

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	<p>both agencies identified subject matter experts (SMEs) to participate in a Kaizen. The goal of this project is to define and establish a consistent process that will assure every Gold Coast Healthcare Plan client within the CCS program has an appropriate medical home specified and documented. After conducting some preliminary research, the Kaizen was kicked off on November 4.</p>			<p>occurs and is documented.</p> <p>This finding is closed.</p>
<p>2.3.1 The Plan's Policy# HS-015, Case Management for Members under 21, wasn't updated to ensure that it defines the meaning or content of the policy.</p> <p>2.3.2 The Plan did not use the correct DHCS Letters and APLs as references for guidance in the development of policies and procedures.</p>	<p>1) The policy has been updated and was approved previously by the last CAP process. As noted in eth pre-audit submission, onsite audit submission and the response back on the draft report this is not the only policy for this membership and other P&P's that were also approved during the last CAP process were provided.</p> <p>2) The correct APL & PL are referenced and checked on P&P's to ensure they are correct.</p> <p>3 & 4) Initially, per the CM Process JAM (provided to the auditors), the COA uses a link (provided by GCHP IT) which shows a monthly updated list of TCRC members which is taken from the State 834 file. This is the</p>	<p>-HS-015 Case Management for Members under 21</p> <p>- HS-021 Developmentally Disabled Members</p> <p>- CM Coordination of Care JAM</p> <p>- Provider Bulletin July 2014</p>	<p>Completed</p>	<p>This item was addressed to the satisfaction of the Managed Care Quality and Monitoring Division in the previous CAP submission. The plan is in compliance with the requirements. However, the audit did uncover areas which can be strengthened.</p> <p>The MCP has submitted its original HS-015, Policy HS-021 Developmentally Disabled Members, CM Coordination of Care JAM, Provider Bulletin July 2014 and explanation regarding recommendation 3 & 4.</p> <p>In order to close all four elements, please provide the updated P&P HS-015 for Members under 21 and corrected document that is referenced. The MCP may update P&P JAM to identify and monitor EI/DD members and a process to ensure EI/DD eligible members receive referrals and consultation services including</p>

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<p>2.3.3 The Plan did not monitor coordinate of care between the Primary Care Providers and Specialists for EI/DD eligible members.</p> <p>2.3.4 The Plan did not ensure that EI/DD eligible Members receive referrals and consultation services including treatments in an efficient and timely manner.</p>	<p>monthly RC file that DHCS provides to the Plan.</p> <ul style="list-style-type: none"> • The Intake COA reviews the referral for processing and follow-up by the HRA Triage Team. This process includes: <ul style="list-style-type: none"> ○ Verifying member eligibility ○ Researching for possible special program participation membership (TCRC/CCS) <p>GCHP Policy HS-021 DEVELOPMENTALLY DISABLED MEMBERS was not utilized by the Auditors in their review of 2.3; however, the Policy HS-021 outlines the process involved for Members with Developmental Disabilities, including identification of members. It appears Policy HS-015 CASE MANAGEMENT FOR MEMBERS UNDER 21 was utilized and referenced for this section.</p> <p>The Primary Care Provider and/or Specialist identify member needs and provide developmentally disabled members with appropriate preventive services and primary care. HS-021, under "Identification of Need" outlines the responsibilities of the PCP and other agencies or processes which may also be useful in identifying these</p>			<p>treatments in an efficient and timely manner.</p> <p>These four elements remain open.</p> <p>2/1/16 MCP submitted CEO approved P&P HS-015.</p> <p>2/5/16</p> <p>The information provided during phone conference that supported MCP's prior explanation of Action Taken is deemed sufficient to assure that MCP has systems in place to prevent a reoccurrence of this finding.</p> <p>This finding is closed.</p>

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	<p>members, which includes providing or arranging for medically necessary diagnostic and treatment services, providing or arranging medically necessary therapies and DME and making referrals to TCRC.</p> <p>GCHP Coordination of Care JAM (job aid) identifies the internal process for identifying TCRC members. This process was verbally explained to the auditors at the time of the interviews as well. Each member is screened for TCRC membership upon referral and a specific process is followed, outlined in the JAM.</p> <p>GCHP Care Managers coordinate care for non-TCRC related services on a case-by-case basis with TCRC. As the member's PCP identifies a patient who should be receiving resources from TCRC who also needs help with coordination of care for a medical problem, the PCP will refer to GCHP CM.</p> <p>Per DHCS Contract Exhibit A, Attachment 11, 11B:</p> <ul style="list-style-type: none"> • <i>2.3: Contractor shall provide all screening, preventive, Medically Necessary, and therapeutic Covered Services to members with DD. Contractor shall refer members with DD to a</i> 			

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	<p><i>Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through RC such as but not limited to Respite, out of home placement, and supportive living. Contractor shall monitor and coordinate all medical services with Regional Center staff, which includes identification of all appropriate services, which need to be provided to the member.</i></p> <p>GCHP Policy HS-021 DEVELOPMENTALLY DISABLED MEMBERS The PCP and/or Specialist is also responsible for providing and/or arranging for all medically necessary services such as diagnosis, specialty or subspecialty consultation, and therapy services to treat the developmental disability.</p> <p>This policy also states that referrals from the PCP and/or Specialist are directed to the Regional Center's Intake Coordinator and outlines what information is required.</p> <p>The CM COORINATION OF CARE JAM (provided to the Auditors) outlines the process for coordination</p>			

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	<p>of care between TCRC and GCHP. GCHP Care Managers coordinate care for non-TCRC related services on a case-by-case basis with TCRC. As the member's PCP identifies a patient who should be receiving resources from TCRC who also needs help with coordination of care for a medical problem, the PCP will refer to GCHP CM.</p> <p>When the GCHP nurse identifies a member with a developmental disability who may require coordination of care, s/he will contact the TCRC Case Manager to verify that member has open TCRC case.</p> <ul style="list-style-type: none"> ○ If yes, required information will be shared to ensure appropriate coordination of health care services. ○ If no, the GCHP nurse will notify the member/member caregiver of TCRC services and referral process ○ If no, the GCHP nurse will also notify the PCP who may also make a referral ○ Medical needs of the member will be managed by GCHP as medically 			

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	<p>necessary.</p> <p>GCHP Policy HS-021 DEVELOPMENTALLY DISABLED MEMBERS speaks to the tracking of members referred to the TCRC as being a shared responsibility between the PCP and/or Specialist and may be requested by GCHP when indicated. It is not the responsibility of GCHP to monitor the PCP for Coordination of Care with TCRC.</p> <p>Providers were reminded by a way of provider bulletin of services/CM resources for DD members in the attached provider operations bulletin.</p> <ul style="list-style-type: none"> ❖ Policy HS-021 DEVELOPMENTALLY DISABLED MEMBERS: (3.C) Upon request, the GCHP Care Manager assists the PCP with identifying the appropriate referral agency and may also assist the PCP in coordinating the member's medical care with the CCRC and/or local government agencies. ❖ The MOU between GCHP and TCRC does not require the Plan to notify the PCP/providers of members receiving services for the Developmentally Disabled. ❖ MOU: Under "Provider 			

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	<p>Outreach and Education”: <u>Regional Center Responsibilities</u> include: Provide Health Plan with current and appropriate TCRC information for distribution to its network providers....<u>GCHP Responsibilities</u>: Provide education and training to plan providers to ensure they are aware of the services available through TCRC. Obtain information resources from TCRC for distribution by Plan to its network or providers...</p> <p>❖ MOU: Under “Referral” a): The Regional Center will identify that the individual is in need of a referral for medical services. “Medical Case Management” b): The Regional Center will provide necessary service coordination.</p>			
<p>2.4.1. The Plan did not have an effective process to monitor completion of the Initial Health Assessment within the required timeframe.</p> <p>2.4.2 The Plan did not ensure that repeated attempts to reach the Member for completion of the Initial Health Assessments are made and documented.</p>	<p>The QI department implemented a more frequent monitoring process beginning in Q1 2015 in order to increase compliance with the IHA requirement. This monitoring now includes monitoring IHA during the Interim review.</p> <p>The QI department recently completed certification of a second nurse as a DHCS FSR nurse and will begin utilizing this nurse to assist in more frequent IHA monitoring. Beginning August 2015, a more</p>	<p>-GCHP QIC mtg IHA Report 1st Q 2015.dc</p> <p>-QIC Mtg IHA MRR & Outreach Monitoring</p> <p>-GCHP QIC Mtg FSR.I.FSR.PARS. Re</p> <p>-IHA Summary</p>	<p>Completed</p>	<p>The MCP has submitted GCHP IHA Monitoring Tools, Q3 Quality Improvement Committee Report ,Q2 Quality Improvement Committee Report indicating no interim reviews were due, Q1 Quality Improvement Committee Report and Examples of clinic Outreach logs.</p> <p>This finding is closed.</p>

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	<p>frequent IHA monitoring was implemented as described below. On a monthly basis, providers who are accepting new members are sent a list of newly assigned members and informed of the requirement to complete the IHA within 120 days. GCHP conducted medical record reviews on a random sample of these members for each provider. Medical record review for monitoring completion of the IHA occurred during the month immediately following the 120 day expiration period. The number of medical records reviewed is consistent with the requirements of DHCS PL 14-004 and based on claims and encounter data indicating the member has had a visit with their PCP.</p> <p>The number of medical records reviewed is consistent with the requirements of DHCS PL 14-004 and based on claims and encounter data indicating the member has had a visit with their PCP.</p> <p>The minimum passing score for the IHA medical record review is 80%. Prior to each medical record review GCHP sends a copy of the Introduction to the Initial Health Assessment (IHA) information sheet. Regardless of the score, upon conclusion of each medical record review, all providers are provided with comments, instruction, and resource</p>	<p>Score</p> <p>-IHA Summary Scor Page.revised 11.5.2015</p> <p>-Clinicas Del Camino RealMay IHA Pages 4</p> <p>-Clinicas Del Camino RealMay IHA Pages 3</p> <p>- Clinicas Del Camino RealMay IHA Pages 2 Clinicas</p> <p>- Clinicas Del Camino RealMay IHA Pages 1</p> <p>-Academic Family Medical Center. IHA.C</p> <p>Dr.Chu.Lang.Chen g.GCHP New Member</p> <p>-Copy of Outreach Log-MAG Sep2015</p>		

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	<p>materials/information regarding the issues identified during the IHA review and a copy of the medical record review report. For sites that do not receive a passing score of 80%, an appointment is arranged for a follow up medical record review to be conducted.</p> <p>Please note that the subsequent QI reports after Q1 now include compliance rates for the IHA. If a member misses any appointments but eventually does come in this is scored on the IHA Review form in question 1.</p> <p>IHA Verification of Outreach Monitoring GCHP is currently developing a method to monitor the outreach conducted for members. When IHAs are completed onsite the FSR nurse reviews the clinic's outreach log to determine that the required attempts have been completed. For those clinics where the IHA review is done offsite via remote access to the EHR, GCHP is now requiring the clinics to submit copies of their outreach logs for review of outreach requirements within seven calendar days of the IHA due date. Upon review of the outreach logs, if any deficiencies exist the FSR nurse instructs all clinics that logs must</p>	<p>-Copy of Outreach Log- Johnflynn Se</p> <p>-Copy of Outreach Log- FILLMORE SEP</p> <p>-Copy of correction_Outreach</p> <p>CMH..CFH..Main. St.Ventura.IHA.Outreach</p> <p>CMH..CFH..Airport. Marina.IHA Outreach</p>		

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	<p>contain the following information:</p> <ul style="list-style-type: none"> • Facility and address • Month of outreach • New member effective date • IHA due date • GCHP member ID # • Last name • First name • DOB • Sex • Address • Phone # • Outreach documentation with dates of outreach • Final status of outreach <p>The plan's FSR nurse is currently working with various clinic systems to standardize their outreach logs across their system. She is also working with the independent providers to assist them in developing outreach logs that meet all requirements.</p>			

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	<p>Compliance reports for outreach are currently under development.</p> <p><u>Attachments:</u> GCHP IHA Monitoring Tools Q3 Quality Improvement Committee Report Q2 Quality Improvement Committee Report indicating no interim reviews were due. Q1 Quality Improvement Committee Report Examples of clinic Outreach logs (Please note Clinicas Del Camino Real utilizes a call center for outreach and therefore has a universal log for all of their clinics)</p>			
Category 3 – Access and Availability of Care				
<p>3.1.1 The Plan did not have an effective tracking system of appointment procedures, prenatal care visits, and waiting times to ensure the monitoring of Member wait times in provider offices.</p> <p>3.1.2 Policy# AA-001, Access and Availability Standards, did not reflect contractual time and distance standards of 10 miles or 30 minutes.</p>	<p>The Plan has replaced policy AA-004, after hour calls and waiting times with policy number NO-007, Waiting Times Standards, and policy NO-006, After Hour call Standard. Policy # AA-001, Access and Availability Standards, has been replaced with Policy NO-009, Access and Availability Standards. Changes have been made to include language requested. In addition, GCHP purchased software from Quest Analytics that will permit the Plan to review time and distance requirements for our members on a monthly basis. An example of the</p>	<p>-NO-006 After Hour Call Standards</p> <p>-NO-007 Waiting times Standards</p> <p>-NO-009 Access and Availability standards</p> <p>-PCP to membership Monthly Monitoring</p>	Completed	<p>The MCP has submitted Policy NO-007 Waiting Times Standards, Policy NO-006 After Hour calls Standard, Policy NO-009, Access and Availability Standards, PCP to membership Monthly Monitoring, and Provider Directory.</p> <p>In order to close elements 3 and 4, please submit the updated Member Handbook to indicate that the appointment for the first prenatal visit must be scheduled within two weeks of Member's request in January 2016 revision and to submit and confirm the date of updated Provider Directory to</p>

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<p>3.1.3 Member Handbook did not indicate that the appointment for the first prenatal visit must be scheduled within two weeks of Member's request.</p> <p>3.1.4 Provider Directory did not ensure that Members have the correct contact information for providers.</p>	<p>tracking and review potential of this new software is attached, document, "PCP to membership Monthly Monitoring."</p> <p>Member Handbook is schedule for revision and in January 2016. Once revisions are made it will be sent to DHCS for review and approval. The revised Member Handbook will include language recommended.</p> <p>Provider Directory has recently been updated and is in the process of being printed. The directory was reviewed by GCHP Network Operations, and corrections made where necessary. Please note with any printed directory it can be outdated before it goes to print which is a systemic industry challenge.</p> <p><u>Attachments:</u> Policy NO-007 Waiting Times Standards <u>Attachments:</u> Policy NO-006 After Hour calls Standard.</p> <p>Policy NO-009, Access and Availability Standards</p> <p>PCP to membership Monthly Monitoring</p> <p>Provider Directory</p>	<p>-Provider Directory</p>		<p>ensure that Members have the correct contact information of their providers.</p> <p>Elements 3.1.1 and 3.1.2 are closed.</p> <p>Element 3.1.3 -Final closure is pending upon receiving the updated Member Handbook. Full compliance estimated date is 2/29//2016</p> <p>Element 3.1.4 -Final closure is pending upon receiving the updated Provider Directory approved by MCOB. Full compliance estimated date is 2/10/2016</p> <p>Elements 3.1.3 and 3.1.4 are provisionally closed.</p> <p>2/11/16 MCP submitted Updated Provider Directory approved by MCOB. Element 3.1.4 is closed.</p> <p>3/2/16 MCP submitted Updated Member Handbook to indicate that the appointment for the first prenatal visit must be scheduled within two weeks of Member's request.</p> <p>Element 3.1.3 is closed.</p> <p>This finding is closed.</p>

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<p>3.2.1 The Plan did not update the Provider Manual and Member Handbook to state that Members needing Urgent Care Appointments should be seen within 24 hours.</p>	<p>Member Handbook is schedule for revision and in January 2016. Once revisions are made it will be sent to DHCS for review and approval. The revised Member Handbook will include language recommended.</p> <p><u>Attachments</u> Policy NO-008 Urgent Care Services Provider Manual Urgent Care Waiting Time Provider-Site Visit</p>	<p>-NO-008 Urgent Care Services-Final -Urgent Car-Screens in Provider Manual -Site Visit Form</p>	<p>Completed</p>	<p>The MCP has submitted P&P NO-008, Provider Manual Urgent Care Waiting Time and Site visit form.</p> <p>In order to close this element, please provide the updated Member Handbook and Provider manual. Estimated date of full compliance 3/30/2016.</p> <p>3/2/2016 MCP submitted Updated Member Handbook and Provider manual that states that Members needing Urgent Care Appointments should be seen within 24 hours.</p> <p>This finding is closed.</p>
<p>3.3.1 When deficiencies or non-compliance was identified with a subcontractor, the MCP did not follow policies requiring a Corrective Action Plan.</p>	<p>The Plan is currently following the policy as related to telephone procedure and after hour's coverage and an improved after hour's policy has been developed, NO-006. In addition, a survey has recently been completed regarding telephone procedures and after hours coverage and we are awaiting the results from our third party vendor, ICE, in late November. Corrective action plans</p>	<p>-NO-006 After Hour Call Standards</p>	<p>Completed</p>	<p>The MCP has submitted its improved P&P NO-006 for after-hours call.</p> <p>This finding is closed.</p>

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	<p>will be implemented at that time if needed.</p> <p><u>Attachments</u> Policy NO-006 After Hour calls Standard.</p>			
<p>3.5.1 Policy# CL-005, Urgent/Emergency Services Claims Reimbursement, did not mandate payment in required timeframes.</p> <p>3.5.2 The Plan did not verify that claims for Emergency Services are paid within the required timeframe.</p> <p>3.5.3 The Plan did not monitoring the timeliness of claims processing for out-of-network Emergency Services.</p>	<p>P&P CL-005 was approved during the last CAP process however as requested the Plan included additional verbiage as requested.</p> <p><u>Attachments</u> CL-005 Urgent Emergency Services Claims Reimbursement _redlined_102115</p>	<p>-CL-005 Urgent Emergency Services</p>	<p>Completed</p>	<p>This item was addressed to the satisfaction of the Managed Care Quality and Monitoring Division in the previous CAP submission. The plan is in compliance with the requirements. However, the audit did uncover areas which can be strengthened and appropriately updated the P&P.</p> <p>The MCP has submitted P&P CL-005 Urgent Emergency Services Claims Reimbursement _redlined_102115.</p> <p>In order to close these three elements, please submit an updated P&P that the misdirected Emergency Services claims are forwarded to the appropriate payer within ten (10) working days of receipt, verification that claims for Emergency Services are paid within the timeframe after the date of receipt by the Plan, and to improve monitoring claims processing to ensure out-of-network Emergency Services claims are paid in timely manner.</p> <p>These three elements remain open.</p> <p>1/22/2016</p>

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	<p>1/26/2016 Per GCHP email: "The report is run every week following the check run to identify any ER or sensitive services claims that were denied. GCHP claims staff then audits the claims to determine if the denial was appropriate. If there are any claims denied in error, an email is sent to Xerox (GCHP ASO) to have the claim adjusted for the next check run.</p>			<p>The MCP has submitted updated and approved P&P CL-005.</p> <p>Element 3.5.1 is closed.</p> <p>In order to close elements 3.5.2 & 3.5.3 the MCP must submit the evidence of monitoring ER claims.</p> <p>Elements 3.5.2 & 3.5.3 remain open.</p> <p>1/26/2016 The MCP submitted ER Services Claims Weekly Audit Report and an explanation of the monitoring process.</p> <p>Elements 3.5.2 & 3.5.3 are closed.</p> <p>This finding is closed.</p>
<p>3.6.1 Policy# CL-006, Sensitive Services and Family Planning Claims Reimbursement did not specify contractual timeframes for payment.</p> <p>3.6.2 The Plan did not verify that claims for Family Planning Services are paid within the timeframe after the date of receipt by the Plan.</p> <p>3.6.3 The Plan did not ensure that the</p>	<p><u>Attachments</u> CL-006 Sensitive Services and Family Planning Claims Reimbursement_redlined_102115</p>	<p>-CL-006 Sensitive Services and Family Plan Claims Reimbursements</p> <p>-3.6.2-3.6.3 Denied Sensitive-Abortion-ER-Services Claims</p>	<p>Completed</p>	<p>This item was addressed to the satisfaction of the Managed Care Quality and Monitoring Division in the previous CAP submission. The plan is in compliance with the requirements. However, the audit did uncover areas which can be strengthened in the P&P. Therefore GCHP updated the policy.</p> <p>The MCP has submitted P&P CL-006 Sensitive Services and Family Planning Claims Reimbursement_redlined_102115.</p> <p>In order to close these three elements, please provide the updated P&P that</p>

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<p>monitoring of claims process is confirming that the out-of-network Family Planning claims are paid in timely manner.</p>	<p>1/26/2016 Per GCHP email: "The report is run every week following the check run to identify any ER or sensitive services claims that were denied. GCHP claims staff then audits the claims to determine if the denial was appropriate. If there are any claims denied in error, an email is sent to Xerox (GCHP ASO) to have the claim adjusted for the next check run.</p>			<p>the misdirected Family Planning services claims are forwarded to the appropriate payer within ten (10) working days of receipt, Verify that claims for Family Planning Services are paid within the timeframe after the date of receipt by the Plan, and Improve monitoring of claims processing to ensure out-of-network Family Planning claims are paid in timely manner.</p> <p>These three elements remain open.</p> <p>1/22/2016</p> <p>The MCP has submitted updated and approved P&P CL-006.</p> <p>Element 3.6.1 is closed.</p> <p>In order to close elements 3.6.2& 3.6.3 the MCP must submit the evidence of monitoring Family Planning Services claims.</p> <p>Elements 3.6.2 & 3.6.3 remain open.</p> <p>1/26/2016 The MCP submitted Family Planning Claims Weekly Audit Report and an explanation of the monitoring process.</p> <p>Elements 3.6.2 & 3.6.3 are closed.</p> <p>This finding is closed.</p>

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3.7.1 The Plan did not sufficiently monitor Member access to at least a 72-hour supply of a covered outpatient drug in an emergency situation.	Per discussion with MMCD, The department is looking into recommendation at a policy level.	-GCHP Pharmacy Network List	Completed	<p>The MCP has not provided any submission for this element.</p> <p>In order to close this element, please provide verification for member access to at least a 72-hour supply of a covered outpatient drug in an emergency situation.</p> <p>12/23/15 The MCP submitted an evidence of 24-hrs pharmacy.</p> <p>The Member access to 72-hrs.drug supply is under development at DHCS.</p> <p>This finding is closed.</p>
Category 4 – Member’s Rights				
<p>4.1.1 The Plan did not Resolve grievances within 30 days as required by the Contract.</p> <p>4.1.2 The Plan did not verify complete medical record review of grievance cases and made sure that this review is documented in the case file.</p>	<p>Resolve Grievances within 30 days as required by contract.</p> <ul style="list-style-type: none"> • 10 Samples of case summaries attached <p>Institutional facilities are starting to utilize Electronic Medical Record systems. One of our largest hospital facilities in our service area utilizes an EMR system. GCHP Nurses have limited access to the EMR system and their access is with view only capabilities. Since GCHP Nurses do not have the ability to print the medical records, GCHP Nurses will document their findings and information in the case files that will state that the medical records were</p>	<p>-G&A File review Sample</p> <p>-GA-003 Member Grievance Resolution Process</p> <p>- Five GCHP Grievance Case examples</p>	Completed	<p>The MCP has submitted 10 samples of G&A for timeliness.</p> <p>In order to close elements 2 and 3, please provide GCHP nurses documentation that shows complete medical record review of grievance case (at least five cases) and to provide the documentation for the process that GCHP has set up to determine if the cases are clinical or non-clinical.</p> <p>Element 4.1.1 is closed.</p> <p>12/23/15 The MCP submitted 5 grievance cases and GA-003 Member Resolution Process.</p>

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<p>4.1.3 The Plan did not consistency distinguish between clinical and non-clinical grievance cases.</p>	<p>viewed from the Cerner system.</p> <p>GCHP G&A department has set up a process for all cases that are received to be reviewed and categorized by GCHP Nurses, to determine if the cases are clinical or non-clinical. Once they have been categorized based on this review the GCHP G&A Specialist will start the research portion of the process and route the cases accordingly.</p> <p><u>Attachment:</u> G&A sample File review</p>			<p>Elements 4.1.2 and 4.1.3 are now closed.</p> <p>This finding is closed.</p>
<p>4.3.1 Policy# HI-006, Incident Response and Reporting, did not include the following contractual stipulation that:</p> <ul style="list-style-type: none"> - For discovery of breach, notify DHCS within 24 hours of any suspected security incident and to be submitted to the DHCS Medi-Cal Managed Care Division (MMCD) Contracting Officer, the DHCS Privacy Officer and the DHCS Information Security Officer. - The investigation of security incident of a HIPAA breach within five (5) working days be submitted to the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer. 	<ol style="list-style-type: none"> 1) HI-006 has been replaced by HI-020 which includes the verbiage requested. 2) GCHP hired a HIPAA Program Manager who started in January 2015 who 	<p>-HI-020 Privacy Incident Reporting_investigations_and Mitigation</p> <p>-PIR Example1</p> <p>-PIR Example 2</p>	<p>Completed</p>	<p>The MCP has submitted its HI-020 replacement for HI-006 and hired HIPAA Program Manager.</p> <p>In order to close these two elements, please submit an updated HI-020 that states; for discovery of breach, notify DHCS within 24 hours of any suspected security incident and to be submitted to the DHCS Medi-Cal Managed Care Division Contracting Officer, the DHCS Privacy Officer and the DHCS Information Security Officer. The investigation of security incident of a HIPAA breach within five (5) working days be submitted to the DHCS Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer and to ensure that Initial Notification of Breach is submitted to the required DHCS personnel within the</p>

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4.3.2 The Plan did not ensure that Initial Notification of Breach is submitted to the required DHCS personnel within the required 24 hour timeframe.	is dedicated to HIPAA Privacy. The Program manager is responsible for timely HIPAA reporting and has met and continues to meet the 24hr reporting requirement.			<p>required 24 hour timeframe.</p> <p>These two elements remain open. 1/22/2016</p> <p>The MCP has submitted an updated P&P HI-020 that contains the required contract language.</p> <p>This finding is closed.</p>
Category 5 – Quality Management				
<p>5.1.1 The Plan did not ensure that the Governing Body reviews and approves the Quality Improvement Program Description and Work Plan at least annually.</p> <p>5.1.2 Plan Quality Improvement policies do not reflect current practices and policies.</p>	<p>All QI policies are now current and have been revised/ reviewed within the last year.</p> <p>QI-023 Potential Quality Issues is currently undergoing review and revision and is due to go to committees on December 3 (Credentials/Peer Review Committee) and December 15 (Quality Improvement Committee) of this year. This policy was last reviewed/ revised June 2014.</p> <p>QI-005 Credentialing Criteria for Organizational Providers recently underwent review/revision via the Credentials/Peer Review Committee on September 10. QI-025 Provider Credentialing also went through revision and review at that time. These will be submitted to the Policy Review Committee on November 18. At the time of the Medical Audit there were numerous individual policies related to provider credentialing. Since the audit these policies have</p>	<p>-Screen shot of Compliance360</p> <p>-PRC Transmittal Forms</p> <p>-QIC Minutes _December</p>	<p>Completed</p>	<p>The MCP has submitted Screen shot of Compliance360 with all QI policies listed and scheduled revision date.</p> <p>In order to close these two elements, please provide a copy of minutes/document on December 3 (Credentials/Peer Review Committee) and December 15 (Quality Improvement Committee) as well as Policy Review Committee on November 18.</p> <p>These two elements remain open.</p> <p>The MCP submitted PRC Transmittal Form and QIC minutes of Dec 2014.</p> <p>This finding is closed.</p>

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	been consolidated into one comprehensive policy; QI-025 Provider Credentialing.			
5.2.1 The Plan did not have appropriate oversight of credentialing activity and review of credentialing policies by all committees tasked with this responsibility.	<p>PLANS RESPONSE: Credentialing activities are reviewed on a quarterly basis at the Credentialing Committee and the outcomes are reported to the QIC on a quarterly basis as well. The governing body (Commission) receives an update relative to credentialing on a quarterly basis in the CMO report. This is reflected in the Commission packet as a part of the CMO report.</p> <p><u>Attachment:</u></p> <p>GCHP Board committee minutes and Packet</p> <p>Approved QIC Minutes</p> <p>QIC Agenda</p>	<p>-GCHP Board committee minutes and Packet</p> <p>-Approved QIC Minutes</p> <p>-QIC Agenda</p>	Completed	<p>The MCP has submitted the GCHP Board committee minutes and Packet Approved QIC Minutes and QIC Agenda.</p> <p>This finding is closed.</p>
5.3.1 The Plan did not verify the written QI Program Description for all elements required by the Contract, including description of activities regarding Access and Availability, Case Management and Care Coordination, and provider review of the QI system.	<p>Recommendation #1 response:</p> <p>Both the Quality Improvement Program Description and Work Plan were completely revised for 2015. These documents were approved at the Quality Improvement Committee (QIC) on March 31, 2015 and</p>	<p>-2015 Quality Improvement Program</p> <p>-2015 Quality Improvement Work Plan</p>	Completed	<p>The MCP has provided its 2015 Quality Improvement Program Description and Work Plan (completely revised for 2015) to meet contractual requirements and were approved at the Quality Improvement Committee on March 31, 2015 along with the 2014 QI Program Evaluation.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion / Expected Completion Date	DHCS Comments
<p>5.3.2 The Plan did not ensure adequate accountability between the QI system and the Governing Body, including annual review of QI documents and QI system improvement recommendations.</p>	<p>presented to the Ventura County Medi-Cal Managed Care Commission on April 27, 2015 for approval. These documents were also submitted to DHCS in July 2015. Page 10 of the QI Program Description addresses activities regarding Access and Availability (specific activities are found in the QI Work Plan).</p> <p>Case Management is described in the Utilization Program Description and activities are the responsibility of the Utilization/Case Management Committee (p. 18 of QI Program Description and p. 7 of the Utilization Program Description). This committee reports up to the QIC.</p> <p>QI activities are communicated to providers via committees, on-site quality visits, provider newsletters and Provider Operations Bulletins. Quality Improvement projects are presented at both the Quality Improvement Committee (QIC) and the Medical Advisory Committee (MAC)(pages 10 – 11 of the QI Program Description) in order to obtain feedback from providers serving on the committees. Responsibilities of these two committees can be found on pages 13 – 15 of the Quality Improvement Program Description.</p>	<p>-2015 Utilization Program Description</p> <p>-2015 Care Management Program Description</p> <p>-QIC agenda March 2015</p> <p>-QIC minutes March 2015</p> <p>-Commission minutes April 2015</p> <p>-Commission packet April 2015</p> <p>-Commission minutes August 2015 (QI Report 2nd Quarter)</p> <p>-Commission packet August 2015</p>		<p>This finding is closed.</p>

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	<p>Recommendation #2 Response: The 2015 Quality Improvement Program Description and Work Plan were completely revised for 2015 to meet contractual requirements and were approved at the Quality Improvement Committee on March 31, 2015 along with the 2014 QI Program Evaluation. These were presented to the Ventura County Medi-Cal Managed Care Commission on April 27, 2015 for approval.</p> <p>The Chief Medical Officer reports quarterly to the Commission to present quality metrics and obtain feedback from Commission members. During the quarterly reports the QI Dashboard is presented which indicates various metrics, their rates and any interventions underway to improve rates that do not meet goal. This provides the Commission with a snapshot into the various QI activities.</p>			
<p>5.4.1 The Plan did not ensure verification of all relevant information to evaluate a delegate's capacity for Quality Improvement is collected and make sure adequate involvement of the Plan's Medical Director in evaluation of health care quality.</p> <p>5.4.2 The Plan did not update and</p>	<p>The Plan reported during the audit period and currently reports delegated activities to the following committees:</p> <ul style="list-style-type: none"> • Compliance Committee (<i>CMO and Associate CMO are members of</i>) • Quality Improvement Committee (<i>CMO is the Chair</i>) • UM Committee (<i>Associate CMO is a member</i>) 	<p>-Board and Committee Packet</p> <p>-DO policies and Job Aide Manual</p> <p>- 5.4 UM Minutes</p> <p>- Q2 APPROVED QIC Minutes</p>	<p>Completed</p>	<p>The MCP has submitted Committee Packets and Minutes.zip, Compliance Committee, Quality Improvement Committee Minutes 9-29-15 DRAFT, UM Committee Minutes, DO-001 & DO-002 and Job Aide Manuals.zip.</p> <p>This finding is closed.</p>

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<p>revise Quality Improvement policies annually or as needed to reflect current Plan procedures.</p> <p>5.4.3 The Plan did not verify adequate reporting to oversight committees for Delegated Quality Improvement activities.</p>	<ul style="list-style-type: none"> Credentialing and Peer Review Committee (<i>CMO Chairs</i>) <p>In addition compliance updates the commission on a monthly basis at the commission meetings.</p> <p>The Plan has retired policy QI-008, "Delegation of Credentialing and Re-credentialing," since the time of the audit. Delegated Activities are conducted in accordance to Delegation Oversight Policy DO-001 "Delegation Oversight – Subcontracting Arrangements," as well as Policy DO-002, "Sanctions-Delegated Subcontractors." Both P&P were approved as a part of the last CAP process. The P&P's were provided to the auditors. The Plan also has a reporting process specified in Job Aide Manuals "DO Monitoring," as well as, "DO document review." The reporting process is robust and is facilitated through the compliance department. Staff provided multiple hard copy binders of each delegate with all of the reporting, reviews of reporting, non-compliance letters, CAPs issued and any other correspondence to the delegate. In addition the electronic process was reviewed during the onsite audit.</p> <p>Both policies and Job Aide Manuals</p>	<p>- Q3 QIC Minutes 9-29-15 DRAFT</p>		

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	<p>are attached.</p> <p><u>Attachments:</u> Committee Packets and Minutes.zip</p> <ul style="list-style-type: none"> • board committee packets 20150824_gchp_amended_packet (Highlighted pages 76-77), and 20150928_gchp_packet (Highlighted 9 & 92) • Compliance Committee (please refer to pages 3; 6-13; 14-43;53-63;76-77; 80-93; 94; 96-109; 122-124;129-147; 150-152; 153-165; 179-181; 187-189;190-206;224-225) • Quality Improvement Committee (please refer to page 7-9 on Q2 APPROVED QIC Minutes 6-30-15, and page 5 Q3 QIC Minutes 9-29-15 DRAFT). • UM Committee (please refer to page 17 on attachment UM Minutes). <p>DO-001 & DO-002 and Job Aide Manuals.zip</p>			

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<p>5.5.1 Policy# QI-024, Medical Records Requirements, did not include the following contractually required elements:</p> <ul style="list-style-type: none"> -Implement an internal monitoring procedure including medical record reviews to ensure that the Providers are compliant with documentation requirements. -Develop, implement, and maintain written procedures of securing and maintaining medical records at each site. <p>5.5.2 The Plan effectively track and monitoring the assignment of members to their Primary Care Providers.</p>	<p>QI-024 Medical Records Requirements was finalized and approved on 12/16/2014. A draft copy of this policy was provided to the auditors at the time on the medical audit.</p> <p>Gold Coast monitors the provisions of the policy as set forth in GCHP Policy QI-003 Primary Care Provider Facility Site Review and is completed for all sites by the plan's FSR nurses. This is stated in QI-024 in the section titled Policy letter B and C. This constitutes GCHP's internal monitoring process and is compliant with the requirements of DHCS MMCD Policy Letter 14-004.</p> <p>Section III Office Management states:</p> <p>H. Confidentiality of personal medical information is protected according to State and federal guidelines. 22 CCR §51009, §53861, §75055; §28 CCR §1300.80; CA Civil Code §56.10 (Confidentiality of Medical Information Act)  </p> <p>1) Exam rooms and dressing areas safeguard patients' right to privacy.</p> <p>2) Procedures are followed to maintain the confidentiality of personal patient</p>	<p>-QI-024 Medical Records Requirements</p> <p>- DHCS MMCD FSR Tool Office Management and accompanying reviewer guidelines_Page 16</p> <p>-DHCS Medical Record Review Survey Tool</p> <p>-GCHP IHA Monitoring Tools</p>	<p>Completed</p>	<p>The MCP has submitted evidence of internal medical reviews to ensure compliance with documented requirements. Additionally, the MCP submitted evidence of a monitoring system which effectively tracks the assignment of PCPs.</p> <p>These findings are closed.</p>

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	<p>information.</p> <p>3) Medical record release procedures are compliant with State and federal guidelines.</p> <p>4) Storage and transmittal of medical records preserves confidentiality and security.</p> <p>5) Medical records are retained for a minimum of 7 years according to 22 CCR Section 75055.</p> <p>Compliance with documentation requirements is monitored via the medical record review and utilizes the MMCD Medical Record Review Tool. Medical records are reviewed for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.</p> <p>Providers who score less than 80 percent on any section in the Medical Record Tool are issued a corrective action plan and are required to submit documentation for verification of correction for any deficiencies noted.</p> <p>Additional internal methods for monitoring are done through the Initial</p>			

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	<p>Health Assessment (IHA) monitoring (see attached example of IHA monitoring forms). The QI department implemented a more frequent monitoring process beginning in Q1 2015 in order to increase compliance with the IHA requirement. This monitoring now includes monitoring IHA during the Interim reviews.</p> <p>The QI department recently completed certification of a second nurse as a DHCS FSR nurse and will begin utilizing this nurse to assist in more frequent IHA monitoring. Beginning August 2015, a more frequent IHA monitoring was implemented as described below.</p> <p>The minimum passing score for the IHA medical record review is 80%. Prior to each medical record review GCHP sends a copy of the Introduction to the Initial Health Assessment (IHA) information sheet.</p> <p>Regardless of the score, upon conclusion of each medical record review, all providers are provided with comments, instruction, and resource materials/information regarding the issues identified during the IHA</p>			

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	review and a copy of the medical record review report. For sites that do not receive a passing score of 80%, an appointment is arranged for a follow up medical record review to be conducted.			
Category 6 – Administrative and Organizational Capacity				
<p>6.4.1 Policy# PR-017, Provider Site Visit, did not indicate that the Plan must provide training no later than 10 (ten) working days after the Plan places a newly contracted provider on active status and shall complete the training within 30 calendar days of being placed on active status.</p> <p>6.4.2 The Plan effectively tracking the training of the newly contracted provider initiate the training within ten (10) working days of being placed on active status and complete the training within 30 calendar days.</p>	<p>GCHP created two separate policies for orientation. Policy NO-001 New Provider Orientation, explains how Provider Relations orient and train new Providers, in either solo practice or associated to a non-delegated medical group, within ten (10) days of contract execution. Attached is an example of the orientation deck that we use to orient new providers as well as two (2) examples of an attestation form signed by providers after the completion of the orientation. The purpose of the second Policy created, NO-003 Oversight of New Provider Orientation for Delegated Groups, is to ensure that documentation is received related to the training of new providers contracted with a delegated group within ten (10) days of being contracted. Attached is an example the provider attestation form used by delegated groups to attest their</p>	<p>-P&P NO-001 -P&P NO-003 -Provider Orientation -Provider site visit for w attestation. -Attestation signed by delegated network groups - Sample of Attestation signed by delegated network groups</p>	<p>Completed</p>	<p>The MCP has submitted Policy NO-001 New Provider Orientation, Policy NO-003 Oversight of New Provider Orientation for Delegated Groups, GCHP Provider Orientation, Provider site visit for w attestation and Sample of Attestation signed by delegated network groups.</p> <p>In order to close these two elements, please submit updated P&P NO-001 & P&P NO-003 to include the completion of the training within 30 calendar days.</p> <p>12/24/15 The MCP submitted updated New Provider Orientation P&P NO-001 and Oversight of New Provider Orientation for Delegated Groups P&P NO-003. Language has been added to the P&Ps to reflect the 30 day training completion.</p> <p>This finding is closed.</p>

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	<p>provider are receiving training within ten (10) days from their hire date. Both policies have been approved by default by DHCS.</p> <p><i>Attachments:</i> Policy NO-001 New Provider Orientation</p> <p>Policy NO-003 Oversight of New Provider Orientation for Delegated Groups</p> <p>GCHP Provider Orientation</p> <p>Provider site visit for w attestation.</p> <p>Sample of Attestation signed by delegated network groups</p>			
<p>6.5.1 The Plan did not verify that all the cases of suspected Fraud or Abuse are reported to the Department of Health Care Services within the required timeframe of ten (10) working days.</p>	<p>The Plan has enhanced FWA tracking process since the audit took place. In order to produce evidence that the Plan is following policy attached FWA-001 and the DHCS contract, the Plan compliance department has implemented the attached tracking log to assure all suspected fraud cases are submitted within the required timeframe of ten (10) working day.</p>	<p>-Policy and Procedure FWA-001</p> <p>-FWA Tracking Log</p> <p>-FWA Case Tracking Log</p>	<p>Completed</p>	<p>The MCP has submitted part of FWA-001 and FWA tracking Log.</p> <p>This finding is closed.</p>
<p>STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS</p>				

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Submitted by: Brandy Armenta
 Title: Compliance Officer/ Director

Date: November 13, 2015