

ATTACHMENT A
Corrective Action Plan Response Form
Plan Name: Santa Clara Family Health Plan



Review/Audit Type: DMHC SPD Medical Survey

Review Period: January 1, 2013 through December 31, 2013

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
Utilization Management				
Deficiency # 1: The Plan does not have effective mechanisms in	In accordance with Santa Clara Family Health Plan's (SCFHP) Policy and Procedure (P&P) UM-5-	SCFHP Utilization Report_CY2014_Q1_Q2_Q3_Q4	Q4 2014	9/11/2015 – SCFHP has submitted documents: Utilization Report_CY2014_Q1_Q2_Q3_Q4, UM Committee agenda 05-06-15, UM

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<p>place to detect and correct under- and over-utilization of health care services.</p> <p><u>Recommendation:</u> Plan must implement a system to detect and correct under- and over-utilization of health care services by at-risk providers.</p>	<p>_08 "UM Over and Under Utilization of Medical Services", SCFHP developed reports to track, monitor and report under and over utilization.</p> <p>Over- and under-utilization of health care services is reported to the Utilization Management Committee quarterly. The UM Committee forwards minutes and reports to the QI Committee.</p>	<p>.xlsx</p> <p> SCFHP_Utilization Report_CY2014_Q1_Q</p> <p>UM Committee agenda 05-06-15.docx</p> <p> UM Committee agenda 05-06-15.doc</p> <p>UM Committee Minutes 05-06-15.docx</p> <p> UM Committee Minutes Signed 05-06-</p> <p>UM Committee agenda 07-15-15.docx</p>		<p>Committee Minutes 05-06-15, UM Committee agenda 07-15-15, UM_Presentation_Utilization_of_Services_Slides_07 15 15, UM Committee agenda 10-08-2014, UM Committee minutes 10-08-2014 FINAL (2), Copy of 04Utilization Report_CY2014_Q1, QI Committee Minutes, and 7-15-2015 Um Committee Minutes. (via separate email sent on 9/15/2015)</p> <p>In reviewing the submitted documents it was noticed that the health plan has implemented a system to monitor, detect and correct under-and over utilization. Reports are presented in the health plans quarterly meetings and discussions are conducted to evaluate this matter.</p> <p>This deficiency is closed.</p>

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		 <p>UM Committee agenda 07-15-15.doc</p> <p>UM_Presentation_Utilization_of_Services_Slides_07 15 15.pptx</p>  <p>UM_Presentation_Utilization_of_Services_Slides_07 15 15.pptx</p> <p>UM Committee agenda 10-08-2014.docx</p>  <p>UM Committee agenda 10-08-2014 F</p> <p>UM Committee minutes 10-08-2014 FINAL (2).docx</p>		

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		 UM Committee minutes 10-08-2014.d Copy of 04Utilization Report_CY2014_Q1.xlsx  Copy of 04Utilization Report_CY2014_Q1.xls QI Committee Minutes  QI Committee Minutes 05-13-15 Sigr		
Deficiency # 2: The Plan does not consistently include in its written response a clear and concise explanation or clinical reasons for	SCFHP has conducted re-training of all staff that process Notice of Action letters to ensure that the correct verbiage is used consistently. A review process has also been put	Training Documents  NOA Letter processPower Point.pr	Delegate training to be completed by 12/1/15	9/11/2015 – SCFHP has submitted documents: Training documents and NOA Letters process Documents submitted by the health plan were reviewed. This deficiency remains open.

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<p>decisions to deny, delay, or modify health care service requests by providers based in whole or in part on medical necessity.</p> <p><u>Recommendation:</u> Plan must ensure that all the NOA letters sent to the members contain a clear and concise explanation or clinical reasons for decisions to deny, delay or modify health care service requests by providers based in whole or in part on medical necessity.</p>	<p>in place which involves RN and Chief Medical Officer review and approval.</p> <p>Annual delegate audits are conducted with review of NOA letters. NOA training will be conducted for delegates through the audit process as well as the Joint Operations Committee meetings conducted with all delegates.</p> <p>9/25/15</p> <p>NOA templates and signed training Attestations are attached.</p>	<p> NOA process 2015.pdf</p> <p>9/25/15</p> <p> Medi-Cal_NOA_Delay_English.doc</p> <p> Medi-Cal_NOA_Denial_English.doc</p> <p> Medi-Cal_NOA_Modify_English.doc</p>		<p>Plan must submit a template for NOA letters and also a signed and dated NOA letter process.</p> <p>10/1/2015 – DHCS has received the requested documents from SCFHP.</p> <p>This deficiency is closed.</p>

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		 Medi-Cal_NOA_Terminate_English.doc  Medi-Cal_NOA_Your_Rights_and_State_Hea  Signed NOA Training attestations.pdf		
<p>Deficiency # 3:</p> <p>The Plan does not adequately monitor the coordination of care provided to its SPD members by tracking, trending, and analyzing the provision and results of: Initial Health Assessments (IHA) and Individual Health Education Behavioral Assessments (IHEBA); and Services for Developmental Disabilities (DD) and the Early Start Program (ESP).</p>	<p>The health plan updated its IHA policy to indicate it monitors IHA compliance rates on a quarterly basis via a report that IT runs. The specifications of the report are attached.</p>	<p>QM006_06 Initial Comprehensive Health Assessment 09102015.docx</p>  QM006_06 Initial Comprehensive Health 120Days_IHA_SPECS 09102015.docx	<p>10/1/15</p>	<p>9/11/2015 – SCFHP has submitted documents: QM006_06 Initial Comprehensive Health Assessment 09102015, 120Days_IHA_SPECS 09102015</p> <p>This deficiency remains open.</p> <p>The health plan must submit a signed and dated Policy No.QM006_06. Also the health plan must send evidence that the methodology for 120 Day IHA calculation and submission is efficiently functioning.</p> <p>10/1/2015 – DHCS has received the requested document from SCFHP.</p>

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<p><u>Recommendation:</u> Plan must develop a system to ensure that the provision and results of IHA, IHEBA and services for (DD) and (ESP) are tracked, trend, and analyzed properly and the coordination of care is provided to the SPD members according to the requirements.</p>	<p>9/25/15</p> <p>The signed policy is attached.</p>	<p> 120Days_IHA_SPECS 09102015.docx</p> <p>9/25/15</p> <p> QM006_06 Initial Comprehensive Health</p> <p> 120Days_IHA_SPECS 09102015.docx</p> <p> IHA_2015_MC_RPT_D raft_012014-122014.d</p> <p> SCFHP IHA Report for CY2014.xlsx</p>		<p>This deficiency is closed.</p>
Availability and Accessibility of Services				
<p>Deficiency # 4:</p> <p>The Plan's Quality Improvement Committee and its governing body do</p>	<p>Specific discussion items of Continuity of Care, Availability and Accessibility and Grievance and Appeals</p>	<p>QI Committee Minutes</p>	<p>10/1/15</p>	<p>9/11/2015 – SCFHP has submitted documents: 05/13/2015 QI Committee Minutes</p> <p>This deficiency is closed.</p>

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<p>not review and evaluate on a quarterly basis, the information available to the Plan regarding accessibility, availability, and continuity of care.</p> <p><u>Recommendation:</u> Plan's QI committee and its governing body must implement and provide a process to at least quarterly monitor, review and evaluate the information they receive regarding levels of accessibility, availability and continuity of care.</p>	<p>have been added to the QI Committee meeting. The Chief Medical Officer will ensure he also incorporates those specific topics into his CMO Board Report.</p>	 <p>QI Committee Minutes 05-13-15 Sigr</p>		
<p>Deficiency # 5:</p> <p>The Plan does not conduct an annual enrollee experience survey to ascertain the accessibility and availability of contracted providers.</p>	<p>An enrollee survey is conducted as part of the annual Timely Access submission. At the time of the 2014 joint audit, the member survey was under way and not available for review by auditors. The Timely Access submission</p>	<p>Timely Access Provider and Enrollee Survey Narrative 2014 and 2015</p>  <p>2014 Submission Provider & Enrollee su</p>	<p>March 31, 2015</p>	<p>9/11/2015 – SCFHP has submitted documents: Timely Access Provider and Enrollee Survey Narrative 2014 and 2015, and Timely Access Member Survey 2014 and 2015 Raw Data</p> <p>This deficiency is closed.</p>

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<p><u>Recommendation:</u> Plan must ensure that annual enrollee experience survey to assess compliance with timely access to care standards is conducted appropriately according to the requirements.</p>	<p>was not due to DMHC until mid-April 2014.</p>	<p> 2015 Submission Provider Enrollee Sur</p> <p>Timely Access Member Survey 2014 and 2015 Raw Data</p> <p> 2014 Submission DMHC_Mbr_Timely_Ac</p> <p> 2015 Submission DMHC Mbr SurveyRaw</p>		
<p>Deficiency # 6: The Plan does not conduct adequate monitoring to ensure member access to specialists for medically necessary covered services.</p> <p><u>Recommendation:</u></p>	<p>The plan is evaluating ways to enhance the monitoring it already conducts to evaluate access to specialty care.</p> <p>Provider Services conducts quarterly network analysis to ensure a sufficient specialty</p>		<p>12/1/15</p>	<p>This deficiency remains open. Please provide evidence that shows the health plan has implemented a process to monitor appropriate accessibility to specialty care. This process must be approved by DHCS.</p> <p>10/6/2015 – DHCS has received the requested documents from SCFHP.</p>

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<p>Plan must implement a monitoring system to ensure that all the members have adequate access to specialist for medically necessary covered services according to the requirements.</p>	<p>network.</p> <p>SCFHP does not require referrals for specialty care. However, Provider Services reviews a monthly LOA report as a way of monitoring out of network referrals. This report is reviewed with the CMO.</p> <p>Grievance and appeals trends access and availability complaints and the Quality Department trends PQI reports.</p> <p>All are reviewed for possible gaps in specialty care and are reported/tracked and trended through the Quality Improvement Committee and to delegates through the quarterly JOC meetings.</p> <p>9/25/15</p>	<p>9/25/15</p>		<p>This deficiency is provincially closed. Please submit the Quality Improvement Committee minutes or any report that indicate the matter was discussed at the meeting.</p> <p>10/19/2015 – DHCS has received the requested documents from SCFHP.</p> <p>This deficiency is closed.</p>

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	<p>The Health Plan has developed a report to monitor member access to specialty care. The report will measure all specialists providing care per thousand members. It will measure specialty care delivered by in-network specialists, out of network specialists and the specialty care delivered by our delegates. The initial report will serve as a benchmark for future comparisons. The report will be submitted to the Quality Improvement Committee for discussion and monitoring. Attached are the report's criteria.</p> <p>10/19/15 DHCS requested copies of QI Committee minutes. Attached are the approved minutes of the February and May meetings.</p>	<p> Provider Specialty Visit Report.xlsx</p> <p>10/19/15</p> <p> QI Committee Minutes 02-11-15 Sigr</p> <p> QI Committee Minutes 05-13-15 Sigr</p> <p> 1st Quarter 2015 Appeals and Grievanc</p> <p> 2nd Quarter 2015 Appeals and Grievanc</p> <p> 2014 Q3 and Q4 PQI Report.pptx</p>		

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	Also attached are the Appeals and Grievance presentations and the PQI report to the committee			
Member Rights				
<p>Deficiency # 7:</p> <p>The Plan does not have procedures to ensure that the person making the final decision for the proposed resolution of a grievance involving a denial based on lack of medical necessity, a denial of expedited resolution of an appeal, or any clinical issues, has not participated in any prior decisions related to the grievance.</p> <p>Recommendation: Plan must provide Policies and a Procedures indicating that the person making the final decision for the proposed resolution</p>	<p>The Plan has been adhering to the process of having a reviewer not involved with the initial decision being available for the appeal. The Plan has appropriately updated the Member Grievance and Appeals Process Policy & Procedure to include that the Medical Director involved in the appeal decision will not be a Medical Director from the initial review.</p> <p>9/25/15: Attached is the signed Grievance Policy.</p>	<p> GA001_11 Member Grievance and Appea</p> <p>9/25/15</p> <p> GA001_11 Member Grievance and Appeal</p>		<p>9/11/2015 – SCFHP has submitted documents: Policy No.: GA001_11 Titled: Member Grievance and Appeals Process. To close this item the plan must submit a finalized and signed P&P GA001.</p> <p>This deficiency remains open.</p> <p>10/6/2015 – DHCS has received the requested document from SCFHP.</p> <p>This deficiency is closed.</p>

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<p>of a grievance involving a denial based on lack of medical necessity, a grievance regarding denial of expedited resolutions of an appeal, or any grievance or appeal involving clinical issues, has not participated in any prior decisions related to the grievance.</p>				
<p>Deficiency # 8:</p> <p>The Plan does not have policies and procedures to enable members to make a standing request to receive all informing materials in a specified alternative format.</p> <p>Recommendation: Plan must provide policies and procedures that enable members to make standing requests to receive all informing materials in specified alternative</p>	<p>Per the request, SCFHP has updated its policy to reflect the practice that members can make standing requests to receive all informing materials in specified alternative formats. A redlined policy is attached.</p> <p>9/25/15</p> <p>The signed policy is attached.</p>	<p> CU 004 Translation and Readability of Wri</p> <p>9/25/15</p> <p> CU-004 Translation and Readability of Wri</p>	<p>9/11/15</p>	<p>9/11/2015 – SCFHP has submitted documents: Policy No.: CU 004 Titled: Translation and Readability of Written Informing Materials</p> <p>To close this item the plan must submit a finalized and signed P&P #CU004.</p> <p>This deficiency remains open.</p> <p>10/6/2015 – DHCS has received the requested document from SCFHP.</p> <p>This deficiency is closed.</p>

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formats.				
Quality Management				
<p>Deficiency # 9:</p> <p>The Plan does not consistently document that quality of care is being reviewed, problems are being identified, and effective action is taken to improve care where deficiencies are identified.</p> <p><u>Recommendation:</u> Plan must implement a system to monitor, evaluate, and take effective action to address needed improvements in the quality of care.</p>	<p>The QI department currently receives potential quality of care issues (PQI) from both Utilization Management (UM) nurses and the Grievance and Appeal (G&A) Department. The QI Department will be conducting training for other departments beginning with G&A, UM, Member Services and Pharmacy on the identification and process for reporting PQI's.</p> <p>The QI Department is also working with Member Services on establishing a quality program for review</p>	 <p>A Peek at PQIs.pptx</p>	<p>Trainings are expected to be completed by 11/1/2015.</p> <p>Quality Program expected to be fully in place by 12/1/15.</p>	<p>9/11/2015 – SCFHP has submitted documents: Power Point material for training which will be completed on 11/1/2015.</p> <p>This deficiency remains open.</p> <p>10/6/2015 – DHCS has received the more supporting documents and responses to the questions from SCFHP.</p> <p>This deficiency is provincially closed. Please submit a report/evidence that demonstrates the implemented system is efficient and operational.</p> <p>10/19/2015 – DHCS has received the requested documents from SCFHP.</p> <p>This deficiency is closed.</p>

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	<p>of call logs by a QI Nurse to ensure that quality issues are not being missed in member calls.</p> <p>9/25/15</p> <p>SCFHP responses to the following DHCS questions:</p> <p>a. Can you show us the process and policy by which the Plan ensures appropriate clinical review of grievances with quality of care issues?</p> <p>The G&A Policy documents that the Chief Medical Officer (CMO) established criteria for identification of medical grievances. The CMO meets with Grievance staff weekly regarding review of grievances. He also reviews the grievance log monthly. If quality of care issues are identified by the G&A Department or the CMO, the cases are forwarded to the Quality</p>	<p>9/25/15</p> <p>a.</p> <p> GA001_11 Member Grievance and Appeal</p> <p> QM002_02 Potential Quality of Care Issues</p> <p> QM009_02 Peer Review Process - sign:</p>		

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	<p>Department. The Quality Department follows its policies regarding PQI and Peer Review. A QI nurse is also a member of the Grievance Committee.</p> <p>b. How does the Plan substantiate that the appropriate clinician has reviewed any potential quality of care concerns?</p> <p>Upon identification of a potential quality issue, the G&A Department completes a PQI referral form that is sent to Quality who conducts a case review. Quality responds to G&A Department referral with a determination of whether or not the case is accepted as a PQI case or no quality issues were identified. G&A sends a response to the member within the grievance timeframe.</p> <p>c. How does the Plan document the determination?</p>	<p>b.</p>  <p>PQI Referral 2014.pdf</p> <p>c.</p>		

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	<p>The decision of whether the G&A case met PQI and outcome of that determination is made in the Grievance Log and via the Grievance Resolution letter.</p> <p>Once in the PQI process, the investigation, findings and assignment of severity level is logged in a confidential access restricted database and case file. (see QM002_02)</p> <p>d. Further, how are determinations monitored? Can you show us a report of your monitoring?</p> <p>10/19/15 DHCS requested a sample report for the quality review of the call logs.</p> <p>Attached is a brief description of the PQI Member Call review process as well as the</p>	 PQI_Log 2015.xlsx 10/19/15  PQI Member Calls Process.docx  PQI_Log Template 10 15.xlsx		

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	template of the log that was revised for documenting all PQI reviews.			

Submitted by: **Beth Paige**
Title: **Compliance Officer**

Date: **October 19, 2015**