DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

October 27, 2023

Alec Nielsen, Compliance
Contra Costa Health Plan
595 Center Ave., Ste. 100
Martinez, CA 94553

RE: Department of Health Care Services Medical Audit

Dear Mr. Nielsen:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Contra Costa Health Plan, a Managed Care Plan (MCP), from August 17, 2020 through August 28, 2020. The audit covered the period of May 1, 2019 through April 30, 2020.

The items were evaluated and 1 of 41 findings was a repeat finding on the subsequent 2021 and 2022 Medical Audits; therefore, DHCS will assess remediation for the 1 repeat finding in the superseding 2022 Corrective Action Plan (CAP). As such, DHCS accepts and will provisionally close the 2020 CAP with finding 5.2.1 still needing remediation. The open finding is transferred to the 2022 CAP which has the same finding. The enclosed documents will serve as DHCS' final response to the MCP's 2020 CAP. Closure of this CAP does not halt any other processes in place between DHCS and the MCP regarding the deficiencies in the audit report or elsewhere, nor does it preclude the DHCS from taking additional actions it deems necessary regarding these deficiencies.

Please be advised that in accordance with Health & Safety Code Section 1380(h) and the Public Records Act, the final audit report and final CAP remediation document (final Attachment A) will be made available on the DHCS website and to the public upon request.

If you have any questions, please reach out to CAP Compliance personnel.

Sincerely,

[Signature on file]

Lyubov Poonka, Chief
Audit Monitoring Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

Enclosures: Attachment A (CAP Response Form)

cc: Stacy Nguyen, Chief
Managed Care Monitoring Branch
Managed Care Quality and Monitoring Division
Department of Health Care Services

Anthony Martinez, Lead Analyst
Audit Monitoring Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

Samounn Pich, Contract Manager
Medi-Cal Managed Care Division
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ATTACHMENT A
Corrective Action Plan Response Form

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Plan: Contra Costa Health Plan **Review Period: 05/01/19 – 04/30/20**

Audit Type: Medical Audit and State Supported Services **CAP Submitted: 01/21/21**

MCPs are required to provide a CAP and respond to all documented deficiencies included in the medical audit report within 30 calendar days, unless an alternative timeframe is indicated in the CAP Request letter. MCPs are required to submit the CAP in Word format that will reduce turnaround time for DHCS to complete its review. According to ADA requirement, the document should be at least 12 pt.

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. The MCP shall directly address each deficiency component by completing the following columns provided for MCP response: 1. Finding Number and Summary, 2. Action Taken, 3. Implementation Documentation, and 4. Completion/Expected Completion Date. The MCP will be required to include project timeline with milestones in a separate document for each finding. Supporting documentation should accompany each Action Taken. If supporting documentation is missing, the MCP submission will not be accepted. For policies and other documentation that have been revised, please highlight the new relevant text, and include additional detail such as title of the document, page number, revision date, etc. in the column "Supporting Documentation" to assist DHCS in identifying any updates that were made by the plan. For deficiencies that require short-term corrective action, implementation should be completed within 30 calendar days. For deficiencies that may be reasonably determined to require long-term corrective action for a period longer than 30 days to completely remedy or operationalize, the MCP is to indicate that it has initiated remedial action and is on the way towards achieving an acceptable level of compliance. In those instances, the MCP will be required in addition to the above steps, to include the date when full compliance will be achieved. Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval, as applicable in accordance with existing requirements.

Please note, DHCS expects the plan to take swift action to implement improvement interventions as proposed in the CAP, therefore DHCS encourages all remediation efforts to be in place no later than month 6 of the CAP, unless prior approval for an extended implementation effort is granted by DHCS.

DHCS will maintain close communication with the MCP throughout the CAP process and provide technical assistance to confirm 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.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
1. Utilization Management				
1.2.1 Written Criteria or Guidelines for Medical Prior and Concurrent Authorizations The Plan used incorrect criteria to deny medical service requests.	1) Get Interqual Contract in place by 2/1/2021 2) Review authorization criteria as a standing item in UM committee meeting and have meeting minutes as a record and update UM policies by 1/31/2021 3) Provide training to UM staff on authorization decisions and priorities by 1/31/2021	1.2.1 Interqual Communication 1.2.1 UM15.002 UR Criteria & Guidelines 1.2.1 UM15.003 Policy for Prior Auth 1.2.1 UM Physician Workgroup Meeting Minutes Oct 2020, Nov 2020, Jan 2021	1) 2/1/2021 2) 1/31/2021 3) 1/31/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Medical Consultation Work group meetings (10/2020) (11/2020) and (01/2021) which provides evidence of documented review and discussion any updates to the Interqual and Apollo system. In addition, to review of EPSDT criteria and outlining that it must be a covered benefit as well as medically indicated. If the provider is unable to provide adequate service, another provider source will need to be replaced. • Updated P&P "1.2.1 UM15.002 UR Criteria Guideline, Policy # UM15.002, (05/19) which has been amended to include a section on Application of Criteria and guideline, which states, "The Physician who is the ultimate decision maker will verify that the nurse who chooses the criteria has made the correct choice." • Updated P&P, Policy # UM15.003, Policy for Prior Authorization, (04/2020) has been updated to reflect services requiring and not requiring a prior authorization and how the staff uses Medi-Cal, Apollo, Medicare, and Health plan guidelines to determine the approval. **TRAINING** • PowerPoint Training, "EPSDT" (2/12/21) and Zoom Confirmation of EPSDT Training for Nurses (02/12/21) and BH (2/19/20) is evidence that the medical staff is receiving training on EPSDT. Training included overview of EPSDT services, EPSDT benefit, role of utilization management, requirements of APL 19-010. • 2021 Medical audit did not reveal deficiency in this area.

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				The corrective action plan for finding 1.2.1 is accepted.
1.2.2 Time Frames for Medical Authorization The Plan did not process routine, concurrent, and retrospective service requests within required time frames. The Plan did not consistently apply its policy regarding timeliness of utilization review decisions.	1) Explore a configuration opportunity in cclink to include both auth request received date and "ready to review" date, which triggers the turnaround time calculation by 3/31/2021 2) Develop a report to monitor the authorization turnaround time on a biweekly/monthly basis by 2/28/2021 3) Review samples of UM requests and ensure they're compliant by 2/28/2021	1.2.2 UM15.003 Policy for Prior Auth 1.2.2 UM Committee Agenda	1) 3/31/2021 2) 2/28/2021 3) 2/28/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policy UM15.003 contains the correct time frames for Medical Authorizations. • Screenshot from cclink system shows that fields were added to trigger turnaround time calculation. **MONITORING AND OVERSIGHT** • Turn Around Time Report dated 5/14/21 demonstrates the MCP is actively monitoring the turnaround time of its authorizations. • Email communication dated 5/14/21, MCP confirmed that internal review of UM request samples was completed for Q1 2021. Internal reviews will be conducted on an ongoing basis. **The corrective action plan for finding 1.2.2 is accepted.**

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1.2.3 Notice of Action (NOA) "Your Rights" attachment The Plan did not update the information included in the "Your Rights" attachment sent with NOA letters, specifically for concurrent cases.	1) Review sample denial letters populated since May 2020 and confirm it includes the updated "Your Rights" attachment including updated DMHC disclosure requirements by 2/28/2021 and requirements related to the Medicaid Final Rules 2) Review all NOA letters to ensure only the standard template is used by 2/28/2021	1.2.3 UM15.015a Timeliness of UR Decision and Communication	1) 2/28/2021 2) 2/28/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policy UM15.015a contains the updated your rights attachment to be used with NOA letters. **MONITORING AND OVERSIGHT** • Results from internal review of "Denial Letters for correct "Your Rights" attachments determined that out of 880 denials reviewed, all had the correct "Your Rights" attachment. **The corrective action plan for finding 1.2.3 is accepted.**
1.3.1 Member Notice to Present Evidence/Testimony for Expedited Appeals The Plan did not inform members of the limited time available to present evidence or testimony in person or in	1) Update the process and policy on notifying members about expedited appeals committee and ability to participate by 2/28/2021 2) Provide training to MS/AGD staff regarding the new process by 2/28/2021 3) Administration staff from the appeal committee will be contacting the members once the meeting time/date is determined 2/28/2021	1.3.1 UM15.015a Timeliness of UR Decision and Communication 1.3.1 MS 8.018 MediCal Appeal_2021-01-21_DRAFT 1.3.1 DESK PROCEDURE EXPEDITED APPEAL 01.2021	1) 2/28/2021 2) 2/28/2021 3) 2/28/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • MS 8.018 Medi-Cal Appeal updated inform member of their ability to participate in Appeal Committee Meeting. • Desk Procedure for Expedited Reconsideration/Appeals was updated to inform the member of their right to participate in the appeals committee and submit medical records. • CRM Expedited Member Appeal demonstrates the MCP instructs member to be informed of their right to participate in the Appeal Committee and inform member to submit medical records prior to Appeal Committee.

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writing sufficiently in advance of the appeal resolution for expedited appeals.		1.3.1 CRM Expedited Member Appeal		**TRAINING** • Member Services Unit Meeting - Training February 26, 2021 minutes demonstrate the MCP trained staff on informing members of their right to participate in the Appeal Committee and inform member to submit medical records prior to Appeal Committee • The Plan revised applicable policies, desktop procedures and provided training. Member acknowledgement letter will be mailed within 24 hours and include the member's right to participate in the appeals process/committee and submit medical records and present additional relevant information. **The corrective action plan for finding 1.3.1 is accepted.**
1.3.2 Written Criteria for Appeals The Plan upheld denials for appeals determinations based on the use of incorrect or unclear written criteria that were more restrictive than Medi-Cal FFS criteria.	1) Conduct training with UM physicians on criteria 2) Regular review on appeal to confirm correct criteria is used	1.3.2 UM Medical Director Meeting 1.14.2020 1.3.2 UM Physician Workgroup Meeting Minutes: Oct 2020, Nov 2020, Jan 2021	1) 1/14/2021 2) 1/14/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Physician Workgroup Meeting Minutes demonstrated Plan staff discusses the use of correct criteria. **TRAINING** • Training material from UM medical directors training from 1/14/21 demonstrate staff trained on the use of correct criteria, • The Plan conducted a training for their Medical Directors on correct criteria. Minutes from Physician Workgroup Meetings demonstrate the Plan regularly reviews appeals to confirm correct criteria is used. The Plan submitted evidence of

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				monitoring through IRR and a ESPDT Referral Turnaround Details spreadsheet which confirms whether correct criteria is used. **MONITORING AND OVERSIGHT** • IRR results summary for Q1 2021 and ESPDT TAP2515 demonstrates the MCP has a process in place to monitor the use of correct criteria for appeals. **The corrective action plan for finding 1.3.2 is accepted.**
1.5.1 Delegation Oversight/Specific Delegated Functions The Plan did not include in its subcontract with a delegate UM responsibilities and specific delegated functions and activities of the Plan and delegate.	MOU was revised and includes the UM Requirements in Section III page 31.	1.5.1 Behavioral Health MOU 12.2020	12/14/2020	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Revised MOU (December 2020) includes a section on Delegate's UM responsibilities: "Behavioral Health staff will follow the Utilization Management requirements· in accordance with the DHCS Contract, Exhibit A and Attachment 5 that describes the regulatory requirement." Section III: Utilization Management Requirements) **The corrective action plan for finding 1.5.1 is accepted.**
1.5.2 UM Delegation Oversight/Ensu	Revised MOU includes the Mental Health Parity rules in Section I pages 2 and 3	1.5.2 Behavioral Health MOU 12.2020	12/14/2020	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES**

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ring Compliance with DHCS Standards/Mental Health Parity The Plan did not ensure a subcontractor met mental health and medical service parity standards established by DHCS. The Plan did not ensure the delegate used comparable processes and applied them no more stringently than those used for providing outpatient medical/surgical benefits.	Also, training of the BH Staff scheduled for January 2021 includes MH Parity Rules (ECD 1/31/2021) -Training Presentation on pages 55-60 in MOU	1.5.2 Staff was trained on the PowerPoint on 12/18/2020		• Revised MOU (December, 2020) incudes section on subcontractor's requirements for mental health and medical service parity standards: "CCHP will assure that BH follows the complete guidelines to the Mental Health Parity rule and support the following objectives from the Medicaid Parity Rules: "A key objective of the Medicaid Parity Rule is to confirm that restrictions or limits are not more substantively applied on mental health and substance use disorder services as compared to medical surgical services." (Pages 2 and 3). **TRAINING** • PowerPoint training, "Behavioral Health Oversight Training" (12/18/2020) and sign-in sheets as evidence that CMU clinical staff received training. The training materials address Mental health parity rules. (MOU, pages 55-60). **The corrective action plan for finding 1.5.2 is accepted.**

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1.5.3 UM Delegate Oversight / Appropriate UM Processes The Plan did not ensure that the delegate used appropriate processes to review and approve the provision of medically necessary covered services.	BH Annual Audit on Dec 9th --checked to ensure Title XI was not being used (Annual Audit Tool) Added BH staff to be users of Apollo Clinical Guidelines. BH Staff schedule for training on the Apollo Clinical Guidelines (ECD 1/31/2021)	1.5.3 Behavioral Health MOU 12.2020 Users were added 11/25-11/30/20 1.5.3 Apollo training was completed 1/13/2021 1.5.3 Apollo Basics (1) 1.5.3 How to Search a Guideline (1) 1.5.3 Viewing the Dashboard and Guidelines	12/14/2020	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Revised MOU (December 2020) states Medicaid Title 9 will not be used for low to moderate service for CCHP Members. Furthermore, CCHP requires Behavioral Health to use the same or better guidelines for parity. Behavioral Health staff must follow CCHP Provider Manual on UM Requirement. The Provider Manual Chapter on UM Requirements will be reviewed annually every January. Section 3 of CCHP UM Program will be discussed. An annual plan is due every year by QI by March 31st that will serve as the roadmap to improving the operations. Additionally, quarterly at the Behavioral Health Meeting, the MCP will review all PA and Denials. And twice at the Quality Council-meeting with documented reports. **TRAINING** • The MCP confirmed the staff training. Apollo training was completed 1/13/2021. Additional BH staff was added to be users of Apollo Clinical Guidelines. **The corrective action plan for finding 1.5.3 is accepted.**
2. Case Management and Coordination of Care				
2.1.1 Health Risk Stratification The Plan did not conduct	1) IT to develop algorithm to stratify SPD members as high or low risk 2) Correct typographical error in SPD HRA policy to reflect risk stratification is	2.1.1 CM policy 16.019 SPD Risk Stratification and Health Risk Assessment	1) 12/1/2020 2) 12/1/2020	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated P&P, "CM16.019: SPD Risk Stratification and Health Risk Assessment and HIF/MET Process" (December 2020) which has been amended to reflect risk

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stratification to identify newly enrolled SPD members as higher or lower risk. The Plan's policy erroneously stated the health risk stratification required completion timeline is 45 days from the member's SPD enrollment date.	completed in 44 days of SPD enrollment 3) Update SPD HRA process and policy to reflect changes	and HIF/MET Process	3) 12/1/2020	stratification to be completed within 44 days of SPD enrollment (page 2). • The updated P&P also includes a section on the MCP's Risk Stratification Process by developing an algorithm to stratify SPD members as high or low risk (page 2): • CCHP relies on the Information Technology Department within our Health Services Department. The Information Technology division uses a risk stratification process based on: o The primary driver of risk based on the history of health care utilization in the last 13 months. o A risk score model designed by looking at the health care utilization data and identifying those characteristics that were most predictive. o A risk stratification process using over 80 pieces of information from three domains (social, medical, & utilization) to predict which patients would be at the highest risk for future care needs. o A risk score designed to identify community members with excess risk of avoidable inpatient admissions and emergency room visits. • The risk stratification will identify members as being high or low risk based on a combination of all the above factors. Stratification score: A score of 0.33 or higher is identified as high risk. A score of 0.32 or lower is identified as low risk. IT will complete the risk stratification within 44 days of SPD enrollment. • Written response from the MCP (02/21/21) explaining the development of their algorithm to stratify SPD members as high or low risk:

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				○ The HRA Stratification that we use has proven to be a phenomenal success in the Whole Person Care Program and the PRIME program. This stratification model is widely accepted in the Managed Care Industry for identifying members who are eligible for Case Management Services. Therefore, we believe this is a highly effective model to get our SPD members into Care Management and improve their quality of life with preventive services to keep them out of the Emergency Room and minimizing IP stays. Furthermore, this HRA stratification model will strengthen our ability to address the Social Determinants of Health for our members due to the success of the WPC model where the SDOH was the focus. The policy and procedure has been updated to indicate the high and low risk scores. **The corrective action plan for finding 2.1.1 is accepted.**
2.1.2 HRA Completion Time Frames The Plan did not conduct HRAs within the required 45 day time frame for newly enrolled members identified as higher risk.	1) Update SPD HRA workflows to ensure the HRA is completed on high risk members identified via the algorithm 2) Conduct staff training to ensure all staff members are educated on the updated process	2.1.2 SPD HRA procedure workflow 2.1.2 Basic Case Management Training Meeting 07.20.2020	1) 12/1/2020 2) 12/1/2020	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated Workflow, "SPD/HRA Procedures" (12/15/20) to confirm the HRA is completed on high risk members identified via the algorithm from Finding 2.1.1. The MCP will obtain TAP report 3711 for newly enrolled SPD member within the first 5 days of the month. Member Service Counselors (MSC) will reach out to the member via telephone call to inquire if they received the HRA form. The MSC will attempt to engage the member to complete the HRA. If the MSC does not reach the member on the first attempt, two follow up calls will scheduled within the next 20 days and will mail another form. The workflow also includes a list of other high priorities to look for using the risk stratification tool. **TRAINING**

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				• Training Agenda, "Basic Case Management Training" (07/20/20) as evidence that MCP staff received training on the updated process. The training reviewed the updated Health Risk Assessment (HRA) Workflow, reviewed Member Services Counselor role in conducting the HRA, reviewed the utilization of TAP report 3711 to identify newly enrolled SPD members, and reviewed the process on how to refer to Complex Case Management, including the list of diagnoses that are considered high risk. **MONITORING AND OVERSIGHT** • Excel Spreadsheet, "SPD HRA Tracking Spreadsheet" (December 2020 – January 2021) as evidence that the MCP has a monitoring procedure by tracking the HRA outreach attempts. The spreadsheet will track if the member is high or low risk, number of calls made, dates of attempted calls, dates of when the HRA form was mailed and received, and HRA completion date. **The corrective action plan for finding 2.1.2 is accepted.**
2.1.3 HRA Outreach The Plan did not consistently implement its policy to send HRA letters to its newly enrolled SPD members or make the	1) Requested a report of all newly enrolled SPD members that have a letter mailed with the HRA 2) Update process for staff on required number of outreach attempts to newly enrolled SPD members 3) Create and implement HRA tracking spreadsheet	2.1.3 SPD HRA procedure workflow 2.1.3 Basic Case Management Training Meeting 07.20.2020	1) 12/1/2020 2) 12/1/2020 3) 12/1/2020	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated Workflow, "SPD/HRA Procedures" (12/15/20) to confirm the HRA is completed on high risk members identified via the algorithm from Finding 2.1.1. The MCP will obtain TAP report 3711 for newly enrolled SPD member within the first 5 days of the month. Member Service Counselors (MSC) will reach out to the member via telephone call to inquire if they received the HRA form. The MSC will attempt to engage the member to complete the HRA. If the MSC does not reach the member on the first attempt, two follow up calls will scheduled within the next 20

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necessary two telephone call attempts to conduct the HRA with the member.		2.1.3 HRA tracking template		days and will mail another form. The workflow also includes a list of other high priorities to look for using the risk stratification tool. **TRAINING** • Training Agenda, "Basic Case Management Training" (07/20/20) as evidence that MCP staff received training on the updated process. The training reviewed the updated Health Risk Assessment (HRA) Workflow, reviewed Member Services Counselor role in conducting the HRA, reviewed the utilization of TAP report 3711 to identify newly enrolled SPD members, and reviewed the process on how to refer to Complex Case Management, including the list of diagnoses that are considered high risk. **MONITORING AND OVERSIGHT** • Excel Spreadsheet, "SPD HRA Tracking Spreadsheet" (December 2020 – January 2021) as evidence that the MCP has a monitoring procedure by tracking the HRA outreach attempts. The spreadsheet will track if the member is high or low risk, number of calls made, dates of attempted calls, dates of when the HRA form was mailed and received, and HRA completion date. **The corrective action plan for finding 2.1.3 is accepted.**
2.1.4 Comprehensive Assessment and Reclassification of HRA results	1) Update SPD HRA workflows to ensure the HRA is completed on high risk members identified via the algorithm	2.1.4 CM policy 16.019 SPD Risk Stratification and Health Risk Assessment and HIF/MET	12/31/2020	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated P&P, "CM16.019: SPD Risk Stratification and Health Risk Assessment and HIF/MET Process" (December 2020) which has been amended to reflect risk stratification to be completed within 44 days of SPD enrollment (page 2).

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The Plan did not comprehensively assess each newly enrolled SPD member's current health risk based on the HRA. The Plan did not have a process to identify members as higher or lower risk based on the HRA.		Process with updated description of the algorithm that has been implemented		• The updated P&P also includes a section on the MCP's Risk Stratification Process by developing an algorithm to stratify SPD members as high or low risk (page 2): • CCHP relies on the Information Technology Department within our Health Services Department. The Information Technology division uses a risk stratification process based on: o The primary driver of risk based on the history of health care utilization in the last 13 months. o A risk score model designed by looking at the health care utilization data and identifying those characteristics that were most predictive. o A risk stratification process using over 80 pieces of information from three domains (social, medical, & utilization) to predict which patients would be at the highest risk for future care needs. o A risk score designed to identify community members with excess risk of avoidable inpatient admissions and emergency room visits. • The risk stratification will identify members as being high or low risk based on a combination of all the above factors. Stratification score: A score of 0.33 or higher is identified as high risk. A score of 0.32 or lower is identified as low risk. IT will complete the risk stratification within 44 days of SPD enrollment. • Written response from the MCP (02/21/21) explaining the development of their algorithm to stratify SPD members as high or low risk:

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				○ The HRA Stratification that we use has proven to be a phenomenal success in the Whole Person Care Program and the PRIME program. This stratification model is widely accepted in the Managed Care Industry for identifying members who are eligible for Case Management Services. Therefore, we believe this is a highly effective model to get our SPD members into Care Management and improve their quality of life with preventive services to keep them out of the Emergency Room and minimizing IP stays. Furthermore, this HRA stratification model will strengthen our ability to address the Social Determinants of Health for our members due to the success of the WPC model where the SDOH was the focus. The policy and procedure has been updated to indicate the high and low risk scores. **MONITORING AND OVERSIGHT** • Excel Spreadsheet, "SPD HRA Tracking Spreadsheet" (December 2020 – January 2021) as evidence that the MCP has a monitoring procedure by tracking members as high or low risk. The spreadsheet will track if the member is high or low risk, number of calls made, dates of attempted calls, dates of when the HRA form was mailed and received, and HRA completion date. **The corrective action plan for finding 2.1.4 is accepted.**
2.1.5 HRA Survey Requirements The Plan did not conduct a complete HRA of	1) Create the CCHP risk stratification process and update the CM policy 2) Develop a turnaround time report for HRA assessment completion	2.1.5 CM policy 16.019 SPD Risk Stratification and Health Risk Assessment and HIF/MET	1) 12/31/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated P&P, "CM16.019: SPD Risk Stratification and Health Risk Assessment and HIF/MET Process" (December 2020) which has been amended to include the HRA required elements in the policy and procedure. CM 16.019 explains the HRA

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newly enrolled SPD members. The Plan did not use a DHCS-approved tool that included all the required elements of an HRA.		Process with updated description of the algorithm that has been implemented 2.1.5 Report pending in IT development	2) 3/31/2021	process and includes the required elements (pages 2 - 4) as mentioned in APL 17-013, Sections B.2.d-m. • An email (06/02/21) which confirms that the MCP stopped using Eliza (the IVR) for HRA. It is now only used for HIF/MET. • Updated Tool, "SPD Health Assessment Tool – Contra Costa Health Plan" (March 2020) which has been amended to include all of the Long-Term Services and Support (LTSS) referral questions verbatim in the tool. **The corrective action plan for finding 2.1.5 is accepted.**
2.1.6 HRA Individualized Care Plans The Plan did not develop individualized care plans for members identified as higher risk based on the HRA results.	1) Implement the process of creating individualized care plans based on the HRA results. 2) Staff training of ICPs	2.1.6 SPD HRA Procedure Workflow 2.1.6 Copy of CCHP - Training Schedule & Rosters 2.1.6 Care Plan Training Guide & Tip Sheet 2.1.6 CoCM - CCHP Complex Case Management Training Guide 2.1.6 CM 16.201 Complex CM Program	1) 1/31/2021 2) 11/20/2020	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated Workflow, "SPD/HRA Procedures" (12/15/20) to confirm that an individualized care plan is created. In the section, "Opening New Case and Entering Assessment Information in EPIC, Step 6 – Care Plan", the workflow describes how to create a care plan in the system. **TRAINING** • Training materials, "CCHP – Training Schedule & Rosters" and, "Coordinated Care Management (CoCM) - CCHP Complex Case Management Workbook" as evidence that plan staff received training on creating individualized care plans based on the HRA results. Page 22 of the CoCM - CCHP Complex Case Management Workbook describes a step-by-step process on how to establish an individualized care plan for the patient.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
		Description		**MONITORING AND OVERSIGHT** • Excel Spreadsheet, “SPD HRA Tracking” (February 2021) as evidence that the MCP has a monitoring process to confirm that individualized care plans for members identified as higher risk on the HRA results are being developed. The spreadsheet tracks if the member has a care plan and the date of the care plan. • Updated Procedure Document, “Tracking Spreadsheet SPD HRA Procedures” (December 2020) which states, the Member Service Coordinator or designee will perform monthly audits by the 15th for the previous month to confirm that: o 3 outreach attempts have been made by the MSC to complete the HRA. o Date the HRA was completed. o The date the HRA was mailed is documented. o High risk members have documentation of CM involvement, whether they were offered CM or declined CM. o If they are enrolled in CM that a individualize care plan is created. o The auditor will document on the spreadsheet indicating that the was complete for each member. **The corrective action plan for finding 2.1.6 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
2.1.7 Required Components of the Initial Health Assessment The Plan did not ensure that all providers performed and documented required components of an IHA: comprehensive history and physical, complete Individual Health Education Behavioral Assessment (IHEBA)/ Staying Healthy Assessment (SHA), and preventive services identified as USPSTF "A" & "B"	1) Update Policy and Procedure to reflect IHA monitoring and provider follow up. 2) Implement medical record review to ensure completion of all IHA required elements 3) Report IHA completion rates and relevant drill down monthly at Quality Council to ensure oversight and identify opportunities for improvement. 4) Send monthly report to providers indicating their members that are due and overdue for their IHA and reenforce all required elements of IHA. 5) Develop a Provider Tip sheet to be used in provider education	2.1.7 QM14.701 Preventive Services and Initial Assessment – Draft to be presented for review and vote at Quality Council on 2/9/21 2.1.7 Draft IHA Cover Letter 2021	1) 2/9/21 2) 2/15/21 3) 2/9/21 4) 3/1/21 5) 3/1/21	The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** • Revised policy, "QM14.701 – Initial Health Appointment" reflect the updates to the APL and a monitoring procedure for measuring compliance with required components: • The Plan sends out a list of new members who are within 120 days of their enrollment but who have yet to complete their IHA as indicated by the IHA Compliance Report to providers each month via email. [PROCEDURE, 2. a. ii. 1., Page 3] o If the compliance rate drops 5% or more over the course of one month, the data will be reviewed for causal factors & a report will be brought to the next Quarterly Quality Council meeting. [PROCEDURE, 1. b. iii., Page 3] o IHA must be completed within 120 days of enrollment, with the exception of if a member refuses an IHA. Refusal may include an active decline or two contact attempts in which the member was non-responsive. [POLICY, 2. c. iv., Page 2] **TRAINING** • The Plan completed a training that demonstrated the Plan addressed the importance of IHAs & key updates to the IHA requirements. This training was presented at the Plan's Monthly CMO meeting & Quality Council Meeting. (See IHA 2.2023). **MONITORING & OVERSIGHT** • Plan policy "QM14.701 – Initial Health Appointment"

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
recommended services, particularly blood lead screening for pediatric members and tobacco smoking cessation/lung cancer screening for adult members.				○ Each month, a compliance report is run by the Plan's Quality Analyst to review the rate of IHA completion. This report stratifies rates by network, provider, & adults/children. [PROCEDURE, 1. b. i., Page 3] ○ Quarterly, a random sample of records is chosen as identified as compliant through the IHA Compliance Report & a RN will complete a chart review to audit for the following: ○ IHA Timely Completion ○ Preventative Care Addressed ○ History ○ Physical ○ Referral Made, if needed ○ Blood Lead Completed or Refusal Documented, if applicable ○ Alcohol & Drug Screening Done, if needed ○ Results are tabulated & analyzed to cross check accuracy of IHA completion, as well as identifying improvement areas in IHA visits. [PROCEDURE, 1. c., Page 3] ○ IHA reports are presented quarterly to Quality Council inclusive of completion rates, trends, drilldown, and improvement efforts. (Supporting documentation from 2022 CAP finding 2.1.1.) **The corrective action plan for finding 2.1.7 is accepted.**
2.5.1 Memorandum of Understanding Requirements The Plan's MOU	Revised MOU and Added an Operational Section, pages 3& 4 Added UM Process for BH on pages 31 & 32. Monthly meetings discussed the UM requirements	2.5.1 Behavioral Health MOU 12.2020 2.5.1 CCHP-BH Meeting Agenda 9.29.2020	12/14/2020	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated MOU Section III, Behavioral Health staff will follow the UM requirements as outlined by the DHCS Contract. The UM Policies must be incorporated with the Workflow of the BH staff. The MCP has created an outline following the necessary

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
with the county MHP did not describe a mutually agreed upon review process for timely resolution of clinical and administrative disputes regarding mental health and other covered services.		2.5.1 CCHP-BH Meeting Minutes 9.29.2020 2.5.1 CCHP-BH Meeting Agenda 11.13.2020 2.5.1 CCHP-BH Meeting Minutes 11.13.2020 2.5.1 CCHP-BH Meeting Agenda 12.8.2020 2.5.1 CCHP-BH Meeting Minutes 12.8.2020		requirements based on PCP and prior authorization requirements to process timely resolution of clinical and administrative disputes. The provider will be responsible in using the BH Low to Mod Prior Authorization Form and submit this with clinical notes for Medical review for services that may be needed in addition. Along with following the 15 step outline to confirm the process is completed correctly. (MCP's written response 02/09/21) • BH/MOU Oversight Meeting Agenda and outline (Sept, Nov, Dec- 2020) which provide evidence of documented review and discussion of MOU related to BH, in resolving clinical and administrative disputes. • Revised MOU indicates MCP contacts responsible for oversight and daily coordination of mental health services. • MOU requires a mutually agreed process for timely resolution of clinical and administrative disputes. Dispute resolution process is outlined and shall apply with requirements in accordance with Title 9, as well as any disputes resolved by DHCS shall be considered final. **The corrective action plan for finding 2.5.1 is accepted.**
2.5.2 Mental Health Services Provided by Primary Care Providers The Plan's policies did not define and	1) Updated policy 9.828 to reflect correct language 2) MOU revised and defines the PCP scope of services for BH on page 2. MOU on page 20 shows the scope of PCP	1) PA9.828 2) 2.5.2 Behavioral Health MOU 12.2020 3) Article in Winter edition to be published	1) January 8, 2021 2) January 31, 2021 3) January 31, 2021 4) January 31, 2021 5) 12/14/2020	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated P & P, Policy PA 9.828, Title: Mental Health Services for Medi-Cal members performed by a PCP or Mental Health Care Provider (11/2020) which has been to include and define services provided by a PCP and those performed by a licensed mental health care provider within their scope of practice. (Pages 2 & 3)

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
describe the mental health services PCPs could provide. Plan policies *PA 9.828* and *UM 15.012 Access to Mental Health Services (reviewed 2/28/19)* incompletely described mental health services PCPs could provide.	practices. 3) 3) Provider Bulletin will cover scope of PCP services (1/31/2021). 4) CCHP Provider Training will cover BH Services & UM Process (3/1/2021). 5) Facility Site Review Nurses will share BH PCP information (6/1/2020). 6) Provider Relations will send out a survey for new PCPs that outlines all BH Services that PCP can perform (6/1/2021. 7) Met with Safety Net Providers on 9/29/2020.	January 2021 4) Information to be shared at the time of a scheduled FSR 5) Information to be shared at the time of a scheduled FSR 6) Draft Survey in process of automation to track PCP's attestation in PMIS database.	6) 12/14/2020 7) 12/14/2020	• MOU revised and defines the PCP scope of services for Behavioral Health. (Pages 2 and 20). • Provide Relations sent out a survey for new PCPs that outlines all BH Services that PCP can perform "PCP Providing Behavioral Health Services Overview Email Notification." Email notifications are saved to the PMIS number for the provider in COLD. • Article that covers scope of PCP services was published Jan 2021 in Winter edition. • The MCP updated its policies to define and describe the mental health services PCPs could provide. **The corrective action plan for finding 2.5.2 is accepted.**
3. Access and Availability of Care				
3.1.1 Procedures of Monitoring Initial Prenatal Appointments The Plan's	1) Update Policy and Procedure to include activities to monitor timely provision of first prenatal appointment. 2) Survey all OB/GYNs and midwives each quarter	3.1.1 QM14.101 Timely Access to Care Standards & Monitoring – Draft to be presented for	1) 2/9/21 2) 2/1/21	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated P&P, "QM14.101:Acess to Care Standards" (01/13/21) which has been amended to include quarterly telephone surveys of all applicable, in-network provider offices to request a first prenatal appointment and document provider

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
procedures did not accurately measure waiting times to obtain first prenatal visit appointments.	through secret shopper calls to ensure appointment availability within 14 calendar days of request. 3) Report results and analysis quarterly at Quality Council to ensure oversight and identify opportunities for improvement.	review and vote at Quality Council on 2/9/21 3.1.1 First Prenatal Appointment Call Script 3.1.1 First Prenatal Appointment Survey	3) 4/13/21	response. **MONITORING AND OVERSIGHT** • Survey Tool, "First Prenatal Appointment" (Q1 2021) is a monitoring tool for the MCP to monitor the waiting time from the initial call to the first prenatal appointment. • Report, "First Prenatal Appointment Availability/March 2021 Quality Council Report" (03/2021 & 07/2021) as evidence that the MCP is monitoring to confirm first prenatal appointments are scheduled within two weeks upon request. • Summary Justification: Plan submitted an updated policy to include a section on Initial Prenatal Visits and implemented a quarterly telephone survey of all applicable, in-network providers to request first prenatal appointment and document provider responses. • The Plan also provided a copy of its survey tool and call scripts as evidence the Plan is monitoring waiting times from the initial call to the first prenatal appointment. • Quality Council Reports were submitted as evidence the Plan is monitoring the availability of the first prenatal appointment. One example indicated a 94% compliance rate. Non-compliant providers were notified and educated on timely access. **The corrective action plan for finding 3.1.1 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
3.1.2 Monitoring of Wait Times at Providers' Offices and Telephone Calls The Plan did not implement its procedures to monitor wait times at provider's offices and wait times to answer and return telephone calls.	1) Update Policy and Procedure to include activities to monitor wait times at providers offices and wait times to answer and return telephone calls. 2) Survey a sample of primary care and specialist providers each month through secret shopper calls to capture time to answer and return phone calls. 3) Survey a sample of patients with recent appointments through telephone calls to ask the length of their in-office wait time. 4) Report results and analysis quarterly at Quality Council to ensure oversight and identify opportunities for improvement.	3.1.2 QM14.101 Timely Access to Care Standards & Monitoring – Draft to be presented for review and vote at Quality Council on 2/9/21 3.1.2 Draft of script for member-facing telephone call survey – Pending DHCS approval	1) 2/9/21 2) 2/1/21 3) 2/15/21 4) 4/13/21	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Drafted Survey Call Script, "In-Office Wait Call Script" (02/01/21) which demonstrates the Plan has a call script when conducting calls to Primary Care and Specialist Providers each month to capture time to answer and return phone calls. • Revised P&P, "QM14.101: Timely Access to Care Standards & Monitoring" (01/13/21) which has been revised to include a section on In-Office Wait Times: The Plan monitors provider network to confirm that members do not wait more than 45 minutes in provider offices from the time they check in at the provider office. A telephone survey is conducted quarterly to members with a recent appointment to their PCP or SCP. **MONITORING AND OVERSIGHT** • Telephone Wait Times (In Office and Return): The Plan monitors provider network to confirm that the time for provider offices to answer their phone does not exceed 10 minutes and that the time for providers to return member phone calls does not exceed 1 day. The Plan conducts quarterly telephone surveys to a sample of providers and tracks answer and return times. • Survey, "In Office Wait Time Responses" (01/21 & 02/21) as evidence the Plan is monitoring members' wait times in provider offices. • Survey, "Telephone Wait Time" (Q1 2021) is a quarterly monitoring tool for the Plan to monitor provider's office wait times to answer and return phone calls.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				• Report, “Telephone Wait Non-Compliance Providers” (03/21) as evidence that the Plan is tracking for non-compliant providers’ in regard to telephone wait times to answer and return telephone calls. Non-compliant providers are informed of survey results and then re-surveyed two months later. • Report, “In-Office and Telephone Wait Times/Q1 2021 Quality Council Report” (Q1 2021) as evidence that the report results, and analysis is reviewed by the Quality Council to confirm oversight and identify opportunities for improvement. • Summary Justification: Plan submitted revised Policy which monitors the provider network to confirm member wait time is no more than 45 minutes in provider offices. In addition, the Plan will monitor provider offices to confirm incoming calls are answered within 10 minutes and to return member phone calls within one day. • Plan submitted two surveys, “In Office Wait Times Responses and Telephone Wait Time” which both are conducted quarterly to members with a recent appointment and to monitor provider’s office wait times to answer and return phone calls. • Plan submitted a Quality Council Report regarding In-Office and Telephone Wait Times which demonstrates that the report results, and analysis is reviewed by the Quality Council to confirm oversight and identify opportunities for improvement. • Plan submitted a Non-Compliance Providers Telephone Wait Time Report which demonstrates that the Plan is tracking for non-compliant providers in regard to telephone wait times to answer and return telephone calls. Non-compliant providers are informed of survey results and then re-surveyed two months later. **The corrective action plan for finding 3.1.2 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
3.5.1 Interest Payment The Plan did not include interest with the late payment of emergency service claims.	1) Improved ER claims audit report to include interest payment at the claim level to monitor any unpaid interest for late claims.	3.5.1 TAP4363_CCHP_DHCS_Claims (ER Audit)	1) 1/12/2021	The following documentation supports the MCP's efforts to correct this finding: **MONITORING AND OVERSIGHT** • "3.5.1 TAP4363_CCHP_DHCS_Claims (ER Audit)" (01/22/21): Emergency Room (ER) Claims audit report provided by the Plan. The revised report includes the Plan's interest payment at the claim level. This report also allows for the Plan to monitor unpaid interested relating to late claims. Columns within the report include but are not limited to, Claim Number, Date of Service, Date of Approval Modification or Denial of Payment, Date of Payment, Amount Paid, and Interest Paid. **The corrective action plan for finding 3.5.1 is accepted.**
3.5.2 Denial of Claims The Plan improperly denied a family planning claim based on other services submitted on the claim.	1) Submit a ticket to change configuration so that codes that do not require PM330 will not be denied for missing PM330 form in the system.	3.5.2 Ticket 492743 3.5.2 Ticket 492743 email confirmation 3.5.2 Ticket 492743 Completion	1) 3/31/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • MCP submitted evidence of system reconfiguration in order to revise the MCP's prior process of denying entire claims if there is a denial reason for one service (line item) in the claim. • System reconfiguration now only denies line items with appropriate denial codes, meaning the MCP's system no longer denies the whole claim, only the affected line items. Reconfiguration has been updated, tested, and placed into production. **The corrective action plan for finding 3.5.2 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
3.8.1 Unaccompanied Minor Written Consent Form The Plan did not collect written consent forms for unaccompanied minors requiring NEMT and NMT services.	1) Update Member Services NMT process and policy on the use of unaccompanied minor consent forms	3.8.1 MS NMT policy	1) 3/31/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Medical Consultants Work Group Meeting Minutes (11/18/20) which provide evidence that the state (DHCS) has agreed that the CCHP PCS form does not always have to be used by the transport company or sending facility. If the transport company or facility uses their own form, as long as it has the required 4 elements, then it would be acceptable. The 4 required elements are: mode of transport, the clinical condition for why NEMT is needed, dates needed and time frame of when needed, and signature of authorizing person. (page 1). **TRAINING** • PowerPoint training, "NEMT Training – APL 17-010" (12/18/20) and sample PCS Forms for Training, as evidence that MCP staff received training. The training informs staff that any form (not just a CCHP form) can be submitted, as long as it has the 4 elements: dates of transportation, mode of transportation, functional limitation justification, physician certification statement. (slide 4). • An email (12/30/20) excerpt to Plan staff which includes information that all PCS Forms are accepted as long as they contain 4 elements: dates of transportation, mode of transportation, functional limitation justification, physician certification statement. **MONITORING AND OVERSIGHT** • Excel Spreadsheet, "NEMT Spreadsheet" (04/23/21) as evidence that the MCP reviews samples on a monthly basis to confirm PCS forms are received for all NEMT requests and confirm that the PCS forms have all 4 necessary elements.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				The corrective action plan for finding 3.8.1 is accepted.
3.8.2 Physician Certification Statement The Plan did not use a DHCS-approved PCS form or a transportation service request form that documented all the required components to determine the appropriate level of service for Medi-Cal members.	1) Review samples on a monthly basis to confirm PCS forms are received for all NEMT rides by 1/31/2021 2) Review samples of PCS forms have all 4 necessary elements by 1/31/2021	3.8.2 NEMT Training 12-18-20 (slides+ packet) 3.8.2 PCS Forms for Training 3.8.2 Medical Consultants Nov 2020 minutes excerpt 3.8.2 UM Physician Update 12-30-20 excerpt	1) 1/31/2021 2) 1/31/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policies and procedures were compliant according to the A&I medical audit report. (Page 38.) Recommendation was to implement the MCP's own policies and procedures. "Plan policies UM 15.064 Non-Emergency Medical Transportation (approved 12/12/19) and UM 16.028.1 Non-Emergency Medical Transportation (approved 7/7/2017) stated the Plan must use a DHCS-approved PCS form to determine the appropriate level of service for Medi-Cal members. The NEMT PCS form must include: the member's specific physical and medical limitations that preclude the member's ability to reasonably ambulate with assistance or be transported by public or private vehicles, dates of service needed, mode of transportation needed, and the prescribing physician's statement certification." As a corrective action for the prior year's audit finding, the Plan stated it would implement policy UM16.028.1 and confirm the use of a DHCS approved form. The Plan did not implement its corrective action. • Medical Consultants Work Group Meeting Minutes (11/18/20) which provide evidence that the state (DHCS) has agreed that if the transport company or facility uses their own form, it must include the required four elements, then it would be acceptable. The four required elements are: mode of transport, the clinical condition for why NEMT is needed, dates needed and time frame of when needed, and signature of authorizing person (page 1).

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				TRAINING • PowerPoint training, “NEMT Training – APL 17-010” (12/18/20) and sample PCS Forms for Training, as evidence that MCP staff received training. The training informs staff that any form (not just a CCHP form) can be submitted, as long as it has the 4 elements: dates of transportation, mode of transportation, functional limitation justification, physician certification statement (slide 4). • PCS Form, “3.8.2 PCS forms for training” – ten samples were included to demonstrate to the staff 4 required elements. See staff training notes. • An email (12/30/20) excerpt to Plan staff which includes information that all PCS Forms are accepted as long as they contain 4 elements: dates of transportation, mode of transportation, functional limitation justification, physician certification statement. **MONITORING AND OVERSIGHT** • Excel Spreadsheet, “NEMT Spreadsheet” (04/23/21) as evidence that the MCP reviews samples on a monthly basis to confirm PCS forms are received for all NEMT requests and confirm that the PCS forms have all 4 necessary elements. • This finding was not found on the 2021 Medical Audit. **The corrective action plan for finding 3.8.2 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
3.8.3 Unenrolled NEMT Transportation Providers The Plan did not ensure contracted NEMT providers were enrolled in the Medi-Cal program.	Reviewed DHCS status for enrollment and certification of all contracted NEMT providers	3.8.3 Enrollment status from DHCS website of CCHP contracted NEMT providers	1/8/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Sample Screenshots, "CHHS Open Data – Enrolled Medi-Cal Fee-for-Service (FFS) Providers" as evidence that the MCP's NEMT providers are enrolled in the Medi-Cal program. This includes the NPI Provider Number, Provider Name, and Enrollment Status Effective Date. • Updated P&P, "CR 11.027: Enrollment and Screening" (December 2020) which has been amended to include a section to confirm providers are enrolled in the Medi-Cal program. • CCHP can access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal Fee for Service providers. This list is compared to the existing network and reviewed when prospective providers apply to join the network. After review, if an existing network provider or prospective provider is not on the list, CCHP can ask the provider if they are enrolled under another MCP and if so, request the "verification of enrollment" document, or direct the provider to DHCS to enroll or CCHP can enroll and screen the provider using DHCS enrollment forms. Should the provider choose to enroll through CCHP, when the process is complete, CCHP will issue network providers a "verification of enrollment" other MCPs can rely on this to prevent enrollment duplication (page 1). **The corrective action plan for finding 3.8.3 is accepted.**
4. Member Rights				

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
4.1.1 Grievance Resolution The Plan sent resolution letters without completely resolving all member complaints.	1) We will keep the grievance in one CRM even if there are multiple issues involved (QS and QC) to ensure the case is fully reviewed and resolved by 1/31/2021 2) Change the policy to ensure the resolution letter addresses all issues within the grievance by 2/28/2021	4.1.1 Appeal Grievance CAP Meeting Minutes 011521	1) 1/31/2021 2) 2/28/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Agenda from 1/11/21 G&A CAP meeting serves as evidence the MPC is planning on keeping grievances on one CRM even if there are multiple issues involved. • Email communication dated 3/5/21 MCP confirmed it has begun its process of combining grievances with multiple issues into one CRM. • Policy MS8.001 was updated to require the review of all resolution letters prior to sending to confirm all issues raised in the member grievance have been addressed. **MONITORING AND OVERSIGHT** • Email communication from 5/7/21 confirms the MCP's quarterly internal member grievance audits include the category of resolution of all member complaints prior to the sending the resolution letter. **The corrective action plan for finding 4.1.1 is accepted.**
4.1.2 Grievance Classification and Processing The Plan inconsistently classified and processed	1) Review samples on a quarterly basis to confirm all exempt grievances are reviewed by clinical staff for proper classification and processing by 1/31/2021 2) Update the policy to include MD or Medical	4.1.2 DRAFT CCS MOU REV 1.15.2021 4.1.2 MS 8.001 Medical Grievance Approved by	1) 1/31/2021 2) 1/31/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • The MCP's written response 02/05/21 affirms implementation of monitoring processes: "CCHP is changing its organizational structure by adding Program Managers that are responsible to work with the Unit Managers and confirm compliance metrics are met. In addition we have started our Self-Auditing Program

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
standard grievances as exempt grievances. The Plan did not consistently implement its procedure regarding exempt grievance classification and processing.	Consultant by 1/31/2021 3) Update process & edit P&P MS 8.001 (Section III - Exempt Grievance, E) to indicate Grievance RN will review all exempt grievances and indicate if grievance will remain exempt or should be reclassified as standard grievance (in addition to classifying as QC vs. QS). Any exempt grievances classified as QC should automatically be reclassified as a standard grievance to allow for a full investigation.	DHCS 2020 May 28_DRAFT_2021-01-21	3) 3/31/2021	that will confirm deficiency are identified and corrected. Finally we are starting a process where the Executive Team is looking at Metrics for accountability. The Executive Dashboard process is starting in Feb 2021." **MONITORING AND OVERSIGHT** • Updated P&P (03/25/21), "AGD20.002: Handling of Complaints and Grievances" (Previously MS8.001) which has been amended to include a section MONITORING AND REPORTING MECHANISM: • The electronic tracking system (CCLink CRM module) shall record and monitor grievances received directly by the Plan or by any entity with delegated authority to receive or respond to grievances. • All exempt, expedited, and standard grievances will be included in the quarterly summary reports of grievance for monitoring, tracking, and reporting purposes. • Each grievance record in the report includes the CRM topic which indicates whether the grievance is standard, expedited, or exempt. • Quarterly summary reports of grievance data will be prepared. These reports should measure trends among grievances in order to detect the need to modify or improve existing programs and services to better serve members and/or to determine the need for additional services. These summary reports will be formally presented quarterly for review and appropriate action to the Plan's advisory body, the Managed Care Commission; the Plan's governing body, the Joint Conference Committee of the County Board of Supervisors; and the Plan's quality assurance committee, the Quality Council. • Grievances shall be reported on a quarterly basis to both the State Department of Health Care Services and the State Department of Managed Health Care. • Grievance reports and logs are run and reviewed on a regular basis to confirm timely resolution of the grievances, including daily identification of those grievances approaching the maximum time limit for resolution. They will also be used to

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				identify trends and other issues for improvement opportunities. • The MCP submitted the evidence of quarterly review of the exempt grievances (Q.3 2020, Q.4 2020 and Q.1 2021). The staff processed a total of 1 exempt-grievances for Q1 2021 which were resolved the same day or next day. There has been a decrease of exempt grievance over Q4 2020. No trends were identified. **The corrective action plan for finding 4.1.2 is accepted.**
4.1.3 Grievance Identification The Plan did not process and resolve all member expressions of dissatisfaction as grievances.	1) Update the process to ensure that if a complaint was previously addressed through a separate appeal/grievance, we should note that in the final resolution letter by 2/28/2021 2) Update the system to include a subtopic for billing related grievance by 2/28/2021 3) Provide training to MS and AGD Staff in regards to billing related grievance by 3/30/2021 4) Conduct an internal audit on all "inquiries" and identify whether those should be grievance by 2/28/2021	4.1.3 Appeal Grievance CAP Meeting Minutes 011521	1) 2/28/2021 2) 2/28/2021 3) 3/30/2021 4) 2/28/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Agenda from 1/11/21 G&A CAP meeting serves as evidence the MPC will designate all expressions of dissatisfaction as grievances including billing issues. • Email communication dated 3/5/21, MCP confirmed that processes have been updated to confirm that if a complaint was previously addressed through a separate appeal/grievance, it will be noted in the resolution letter and the system has been updated to include a subtopic of billing related grievances. • Email communication dated 3/5/21, Member Service Unit Meeting Minutes from 2/26/21, Member Services Claims Workflow serve as evidence the MCP trained its staff in regards to billing related grievances. **MONITORING AND OVERSIGHT** • Internal Audit for All Inquires Results demonstrate the MCP is monitoring inquiries received to determine if they are being classified properly. Audit results contain systemic actions taken by the MCP. Audits will be conducted on a quarterly basis.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				The corrective action plan for finding 4.1.3 is accepted.
4.1.4 Quality of Care Grievance Identification The Plan did not ensure all quality of care issues were referred to the Medical Director.	1) Update the process and policy to ensure all grievances are reviewed by the grievance nurse and Medical Director or Consultant for appropriate clinical review and classification by 2/28/2021 2) Conduct an internal audit to ensure all QC grievances include both RN and MD's review by 2/28/2021	4.1.4 Appeal Grievance CAP Meeting Minutes 011521 4.1.4 AGD 20.001 Provider and Facility Appeals Process	1) 2/28/20201 2) 2/28/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Agenda and minutes from 1/11/21 G&A CAP meeting confirm the MCP will have the Medical Director or designee review for PQI. • Policy MS8.001 was updated to confirm that all quality of care grievances are reviewed by the Medical Director. **MONITORING AND OVERSIGHT** • Email communication from 3/5/21 confirms MCP completed its internal audit of quality of care grievances. • Email communication from 5/7/21 confirms the MCP's quarterly internal member grievance audits include verification that all quality of care grievance are reviewed by the medical director. **The corrective action plan for finding 4.1.4 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
4.1.5 Capturing all Grievances at Provider's Offices The Plan's grievance system did not capture and process all complaints and expressions of dissatisfaction. This was a finding in the prior audit. As a corrective action, the Plan revised its new provider training materials and informed providers in its summer 2019 provider bulletin that grievances regarding providers were to be sent to the Plan for resolution.	1) Develop a feedback loop to ensure providers forward all grievances to CCHP 3/31/2021 2) Proactively reach out to provider groups to confirm any receipt of grievances 3/31/2021	4.1.5 CCRMC Provider Orientation PowerPoint 01.15.2021 4.1.5 CPN PCP Orientation PowerPoint 1.14.2021 4.1.5 CPN Specialist Orientation PowerPoint 07.2020 4.1.5 CPN Urgent Care Orientation PowerPoint 07.2020 4.1.5 Provider Email - CCHP Member Complaints and Grievances	1) 3/31/2021 2) 3/31/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • The MCP's written response (03/29/21) confirms implementation of monitoring procedures and update to its procedures: "To address the gap between when the Provider is given education about CCHP's expectations and the actual resolution of the grievance, even if it is filed in the provider's office, CCHP proposes to amend the Provider letter, Provider Orientation, Provider Bulletin and add to our provider contracts to state "All member grievances, even those where a member does not use the term "Grievance" to complain or express dissatisfaction, must be submitted to CCHP immediately." • The MCP updated Provider letter, Provider Orientation, Provider bulletin and provider contracts to state that "Oral complaints at provider offices must be re-directed to CCHP Member Services or documented in the CCHP Member Grievance form by the provider and forwarded immediately to CCHP." **MONITORING AND OVERSIGHT** • The MCP submitted internal audit results "July 2021 Provider survey" and analysis to gage the implementation of the CAP and as evidence of monitoring efforts. • The Plan was found to be compliant in the 2021 audit, thus this was not found to be a repeat finding. **The corrective action plan for finding 4.1.5 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
4.1.6 Report of Grievances to Quality Assurance Committee The Plan did not report all grievances to the quality assurance committee at least quarterly.	1) Include grievance reporting to the quarterly QC Meeting by 1/31/2021	4.1.6 Quality Assurance Committee Communication 4.1.6 Appeal Grievance CAP Meeting Minutes 011521 4.1.6 MS 8.001 Medical Grievance Approved by DHCS 2020 May 28_DRAFT_2021-01-21	1) 1/31/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated P & P, "Handling of Complaints and Grievances," Policy # MS 8.001, (05/28/2020) which has been amended in multiple sections. This includes updates to the Grievance data being reported quarterly vs. semiannually to the Plan's Quality Council. Reports and data are assembled to analyze trends and areas of focus. (Pg. 8, Q). The MCP will also keep a log of all grievances and the data will be reviewed by Member Services Manager and will be discussed with Quality Management and Council (p.9, X). Exempt Grievance Procedure Section has been updated to notate grievances will be reported on a quarterly basis and review by the Medical Consultant (M.D) and Nurse. These grievances will be classified as either: Quality of Service, quality of care, or access issues (AC). The review team will determine if the be grievance remain exempt or reclassified as a standard grievance. (P.11-12, sec III) • 4.1.6 Attachment A – Minutes 2021-06 FINAL. - Quality Council Meeting Minutes 2021-06 FINAL as evidence the quarterly grievance report is being discussed, comparing quarterly numbers and identification of potential trends. • 4.1.6 Q1 Grievance Appeal Report • 2021 Medical Audit Report did not reveal a finding in this area. **The corrective action plan for finding 4.1.6 is accepted.**

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4.1.7 Grievances Alleging Discrimination The Plan did not forward grievances alleging discrimination to DHCS for review and appropriate action.	1) Update policy and process to ensure all discrimination cases will be forwarded to DHCS and the contract manager after the grievance is closed 2/28/2021	4.1.7 Appeal Grievance CAP Meeting Minutes 011521 4.1.7 AGD 20.001 Provider and Facility Appeals Process	1) 2/28/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Agenda and minutes from 1/11/21 G&A CAP meeting confirm the MCP will update policy to confirm discrimination grievances are submitted to DHCS for investigation. • Updated Policy MS8.001 confirms all discrimination grievances are submitted to DHCS for investigation. **The corrective action plan for finding 4.1.7 is accepted.**
4.2.1 Children with Special Health Care Needs (CSHCN) The Plan did not address the needs of the children with special health care needs.	1. C&L Manager will be part of CCHP's CCS Workgroup and attend Quarterly meetings with updates. 2. C&L Manager will do at least two trainings with the CCS Case Managers to ensure C&L needs of children with special needs are met. 3. C&L Manager will expand the Population Needs Assessment report to include more details on services for children with special healthcare needs 4. Develop stand alone PNA	4.2.1 CLHE20.010 Population Needs Assessment - Draft 4.2.1 Draft updated C&L Program Description 4.2.1 Email to plan trainings	1) 2/30/21 2) 12/30/21 3) 6/30/2021 4) 1/30/21	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • An email (01/15/2021) which includes a description of the MCP's outline to support the Population Needs Assessment report, which will include Children with Special Needs. The MCP will also be attending CCS workgroup meetings and conducting two trainings to confirm their Case managers are aware of all services, including: Interpreter, American Sign Language, documents in Braille, large print, audio, etc. • Updated P & P, Cultural and Linguistic Program Description (page 3) which will include yearly Population Needs Assessment, this will evaluate health education/cultural and linguistic needs of the members. The plan will also address Populations needs ensuring that special needs of seniors and persons with disabilities. • Updated P & P - "Population Needs Assessment Implementation," Policy #CLHE

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	policy and update C&L Program Description			20.010, (01/2021) serves as evidence that the MCP has updated their Population Needs Assessment to address the following areas: children with special health care needs, special needs of seniors and persons with disabilities and members with limited English Proficiency, as well as other member subgroups. • Quarterly Meeting Agenda and PowerPoint Training, "Serving Children with Special Needs" is evidence that the MCP is addressing the needs of children with Special Education needs. **The corrective action plan for finding 4.2.1 is accepted.**
4.3.1 Background Check The Plan did not ensure that all employees with PHI access had complete background checks.	1) Determine the list of current CCHP staff whom personnel cannot locate the background check record 1/15/2021 2) Make a final decision on whether personnel could perform the background checks or CCHP can do it our own 1/31/2021 3) Develop a policy and a MOU with HSD Personnel to give us their checklist to show background check done 3/31/2021	4.3.1 CCHP Background Policy 1.11.21 DRAFT_	1) 1/15/2021 2) 1/31/2021 3) 3/31/2021	The following additional documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • "4.3.1 Personnel Policy 02-23" The Plan submitted an updated Personnel Policy, "CCHP Personnel Hiring and On-boarding" committing the Plan procedural steps for background checks for all employees. (Page 2). **MONITORING AND OVERSIGHT** • Email Attachments: o The Plan demonstrated it followed up on employees requiring background checks in "4.3.1 Email Attachments". • "4.3.1 Response 05.31.23" The Plan reviewed its full-time employees, temps and consultants to ensure that the appropriate documentation was in the member's files/records. They have been working with Contra Costa County HR and Health Services Division Personnel. The Plan reviewed all staff, regardless of their tenure

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				status, to ensure they all had a Background Check. As of 6-1-2023, the Plan updated the Compliance Unit with the following statistics: o 252 Current Employees o 99.6% completed Scans o 100% completed Sanctions (1 employee on LOA and will not return to work until a scan is completed; Plan responded that last (1) employee continues to be on FMLA as of August 2023.) (Supporting documentation from 2022 CAP finding 4.3.1.) **The corrective action plan for finding 4.3.1 is accepted.**
5. Quality Management				
5.1.1 Investigation of Potential Quality Issues The Plan did not thoroughly investigate and evaluate potential quality issues prior to closing cases.	1) Update policy to indicate the PQI needs to be fully resolved at the best of CCHP's ability before closing cases. Created a new category in the system to track PQI as a separate CRM by 1/31/2021 2) Conduct internal audit on PQI cases to ensure the case is fully investigated 2/28/2021	5.1.1 QM14.502 Potential Quality Issues	1) 1/31/2021 2) 2/28/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated P&P, "QM14.502: Potential Quality Issue" (08/07/20) which has been revised to include the thorough investigation process. Once the Medical Director/Consultant is satisfied with the completeness of relevant information, the PQI case is then sent to the PQI Committee. On a bi-weekly/monthly bases, the PQI Committee does a complete review of all PQI cases. The PQI is closed when the Medical Director determines that the review is complete and the issue is fully resolved at the best of the health plan's ability. **MONITORING AND OVERSIGHT** • Internal Audit, "PQI Cases Audit" (01/05/21-01/14/21) as evidence that the MCP is monitoring PQI cases to confirm the case is fully investigated. **The corrective action plan for finding 5.1.1 is accepted.**

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5.1.2 PQI Delegation Agreement The Plan did not describe specific delegated quality improvement activities and reporting requirements for PQIs adjudication in the delegation agreement with one delegate.	(1) Updated MOU with CCRMC (2) At February Quality Meeting will review Send the updates to CCRMC Quality Director (3) CCRMC JOM to discuss with Executive leadership	5.1.2 Delegation Agreement CCRMC signed - sharron	1) January 19, 2020 2) February 9, 2021 3) March 31, 2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • An email (04/16/21) which informs DHCS that the MCP will manage its own Potential Quality Incident PQI program. MCP is sending these changes to the CCRMC Quality for their review and agreement. • Revised P&P, "NO. 616: "Patient Grievance/Complaint Process (04/16/21) which has been revised to indicate that the MCP will manage its own Potentially Quality Incident (PQI) program. It also outlines reporting requirements. • Revised Delegation Agreement, "Contra Costa Health Plan Delegation Agreement", (04/16/21) which has been updated to indicate plan responsibilities and specific delegate functions and reporting requirements. MCP has also revised agreement to assume sole responsibility for any Potential Quality Issues to be managed by the MCP. **The corrective action plan for finding 5.1.2 is accepted.**

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5.2.1 Ownership and Control Disclosures of Delegates The Plan did not ensure collection and completion of ownership and control disclosure forms.	1)Revised desk process. 2) Created a review tool. 3) Trained contract unit staff. 4) Auditing all DHCS Disclosure documents collected from 5.1.2020 - current for accuracy.	5.2.1 Desk process 5.2.1 Review tool 5.2.1 Power Point Training 5.2.1 Staff attendance roster	1) 1/7/2021 2) 1/7/2021 3) 1/7/2021 4) 4/1/2021	DHCS has identified that finding 5.2.1 is a repeat finding on the subsequent 2021 and 2022 medical audits; therefore, DHCS will assess remediation for finding 5.2.1 in the superseding 2022 corrective action plan. The open finding is transferred to the subsequent CAP which has the same finding.
5.3.1 Completion of Provider Training The Plan did not ensure it conducted provider training within ten working days after placement on active status for all newly contracted providers.	1) Revised desk process for CPN and RMC Networks. 2) Updated PA 9.816. 3) Trained staff responsible for task of launching and tracking the orientations. 4) Train Provider Relations staff using existing Power Point 5) Monitor orientations as providers join the network for timeliness. **The MCP update 03/29/22:** Provider Relations has clarified that the process had changed. The orientations are being	5.3.1 CCHP New Facility Orientation SOP 1.4.21 5.3.1 CCHP New Provider Orientation SOP 1.4.215.3.1 CCRMC New Provider Orientation SOP 1.4.21 5.3.1 PA 9.816 Provider Training 12.20 5.3.1 Power Point for staff Training 5.3.1 PR Sign In	1) 1/12/2021 2) 12/2020 3) 1/12/2021 4) 1/31/2021 5) 1/31/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Redlined CCHP Delegated Credentialing Agreement Template – Tertiary Care rv2.22 was revised to include the Plan's oversight processes. CCHP will review the monthly update rosters, enter new providers in the database and place active in the CCHP network. Any provider that doesn't complete the new provider orientation during the onboarding process, will not be listed on the monthly rosters sent to CCHP. Only providers listed on the monthly rosters will be added to the CCHP network and placed active by CCHP in the network. Monthly rosters will be submitted to the next scheduled PRCC for review and approval. **MONITORING AND OVERSIGHT** • Revised P&P "PA 9.816 Provider Training" (rv2.22). The Plan has revised the language now to include monthly monitoring as its "continuous effort" of monitoring & reporting on a quarterly basis to the Plan's Peer Review and Credentialing Committee (PRCC).

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	performed during the onboarding process by the delegated entity. The MCP had submitted a revised desk procedure and P&P for 5.3.1. The delegated credential language was accurate.	sheet - Provider Orientation Training 1.12.21 **The MCP update 03/29/22:** Revised P&P "PA 9.816 Provider Training" (rv2.22) - Redlined CCHP Delegated Credentialing Agreement Template – Tertiary Care rv2.22		**The corrective action plan for finding 5.3.1 is accepted.**
5.3.2 Delegated Provider Training The Plan did not specify training responsibilities for newly	1) Revised delegated credentialing agreements. Sent out to delegates for signature 2) Scheduling quarterly/semi- annual meetings with delegates	1) 5.3.2 Delegated credentialing template, executed agreements for CCRMC, JMPN, CFMG,	1) 3/29/22 2) 3/29/22	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Revised P&P "PA 9.816 Provider Training" (rv2.22). The Plan has revised the language now to include monthly monitoring as its "continuous effort" of monitoring & reporting on a quarterly basis to the Plan's Peer Review and Credentialing Committee (PRCC).

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contracted providers in written agreements with four delegates.	**The MCP update 03/29/22:** Provider Relations has clarified that the process had changed. The orientations are being performed during the onboarding process by the delegated entity. The MCP had submitted a revised desk procedure and P&P.	Stanford, Lucile Packard, UHA and UCSF. 5.3.2 E-mail to Stanford (includes Lucile Packard and UHA), UCSF and CFMG, Pending response. **The MCP update 03/29/22:** - Redlined CCHP Delegated Credentialing Agreement Template – Tertiary Care rv2.22 - Revised P&P "PA 9.816 Provider Training" (rv2.22)		• "The delegated entities orientation is performed at the time of "onboarding" and prior to being credentialed by the entity and delivering services to any member. Delegated entities have linked CCHP's Provider Manual to their orientation process which is reviewed by the prospective provider. If a provider doesn't complete the training, the delegated entity excludes them from the monthly rosters sent to CCHP. Providers are required to sign an attestation to acknowledge, which is stored in their electronic credential file or the delegated entities Human Resources Department. This process is part of the responsibilities delegated to the entity in the Delegated Credentialing Agreement. • CCHP receives monthly rosters from the delegated entities listing the providers that have been credentialed, to confirm that the delegated organizations orient new providers prior to performing services, CCHP is responsible to enter the new delegated providers into the database and place them active in the network. In the event of a discrepancy, the provider would be placed inactive in the network and a corrective action plan issued to the delegated entity to complete and return within thirty (30) business days. Orientation monitoring will be done on a monthly basis and the results reported to the Peer Review and Credentialing Committee (PRCC) quarterly." (Page 2). **MONITORING AND OVERSIGHT** • Redlined CCHP Delegated Credentialing Agreement Template – Tertiary Care rv2.22 was revised to include the Plan's oversight processes. CCHP will review the monthly update rosters, enter new providers in the database and place active in the CCHP network. Any provider that doesn't complete the new provider orientation during the onboarding process, will not be listed on the monthly rosters sent to CCHP. Only providers listed on the monthly rosters will be added to the CCHP network and placed active by CCHP in the network. Monthly rosters will be submitted to the next scheduled PRCC for review and approval.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				• A sample Delegated Entity Roster received monthly from the delegated entities listing the providers that have been credentialed. Any provider that doesn't complete the new provider orientation during the onboarding process, will not be listed on the monthly rosters sent to CCHP. **The corrective action plan for finding 5.3.2 is accepted.**
6. Administrative and Organizational Capacity				
6.1.1 Delegated Health Education The Plan's written agreement with a delegate did not specify the delegate's responsibility to provide and evaluate health education services.	1) CCHP has made the decision to de-delegate Health Education. Delegation agreement with CCRMC will be terminated. A de-delegation letter will be included with CAP response. 2) Health Education program for CCRMC members will be conducted through CCHP directly as with other non-delegated providers. CCHP will ensure programs, services, functions, and resources are provided for health education, health promotion and patient education for all members and overseen by the CCHP Health Educator.	6.1.1 Notice of Non-Delegation 1.11.2021.pdf 6.1.1 01062021_CCRMC HE delegation audit tool 2020.xlsx 6.1.1 QM14.301_Delegation Oversight Process	1) 1/18/21 2) 1/18/21 3) 2/17/21	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • The Plan made the decision to de-delegate Health Education, assuming full responsibility for its Provider Networks to evaluate Health Education classes. The Plan confirmed in writing their decision to de-delegate & assume full responsibility. (6.1.1 Notice of Non-Delegation 1.11.2021.pdf). • The Plan has terminated their delegation agreement to provide Health Education with the Contra Costa Regional Medical Center (CCRMC) effective 1/18/21. Letter to CCRMC submitted as evidence. (6.1.1 01062021_CCRMC HE delegation audit tool 2020.xlsx). The Plan is redesigning its health education system and creating a health education council. • The Plan will confirm programs, services, functions, and resources are provided for health education, health promotion and patient education for all members and overseen by the Plan's Health Educator. (6.1.1 01062021_CCRMC HE delegation audit tool 2020.xlsx). • The Plan submitted a revised Delegation Oversight Process which reflects all new

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	3) A Health Education Council will be held quarterly to connect with health education providers and FQHCs to share information about resources in the community and coordinate delivery of health education to members			changes to their Heath Education Services & clearly delineates its responsibility. (6.1.1 QM14.301_Delegation Oversight Process). **The corrective action plan for finding 6.1.1 is accepted.**
6.2.1 Reporting Potential Fraud, Waste, or Abuse incidents The Plan did not report all suspected fraud, waste or abuse cases to DHCS within ten working days.	1) Beginning with Q4 2020, all TRAP reports will be reported to Program Integrity Unit within 10 working days of receipt, with notification that CCHP will commence an internal investigation to verify allegations. by 1/31/2021 2) These changes will be amended in CCHP's FWA P&P and documented in CCHP's Compliance, Fraud Subcommittee on January 11, 2021.	6.2.1 ADM1.006	1/1/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • The Plan contracts with Health Management Systems (HMS) to receive quarterly reports in an effort to prospectively detect cases of suspected fraud, waste, and abuse (FWA). CCHP acknowledged that HMS and CCHP must follow the same FWA contractual reporting requirements. • "6.2.1 ADM1.006 fraud policy 6-2000 Rev 2021" (01/22/21): Administration policy provided by the plan. The policy outlines the plans efforts in contracting with a third party organization to prospectively detect activity and receive data of suspected cases of FWA. Plan policy outlines the implementation of a new verification form to be completed, by the CCHP Compliance Officer, in an event FWA has been suspected. • "6.2.1 ADM1.006 fraud policy 6-2000 Rev 2021" (4/16/21): Revised administration policy provided by the plan. Revisions include steps that confirms all suspected FWA cases are reported to DHCS within 10 working days. Policy revisions include clarification on existing requirements and fraud guidelines the plan must following when processing suspected cases of FWA.

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				The corrective action plan for finding 6.2.1 is accepted.
6.2.2 Fraud, Waste, and Abuse Investigations The Plan did not investigate all identified suspected fraud, waste, or abuse issues.	1) CCHP has created a "Verification Form" to ensure that all identified issues are documented and investigated. 2) Update the process to have compliance officer to review and confirm the verification form	6.2.2 Verification Form 6.2.2 ADM1.006	1/1/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • The Plan has created a "Verification Form" to confirm that all identified issues are documented and investigated. (6.2.2. Sample Verification Form). • The Plan revised its fraud policy & procedure to include its updated process. (6.2.2 ADM1.006 fraud policy 6-2000 Rev 2021). • The Plan will confirm that all identified suspected fraud, waste, or abuse issues are investigated with the new process, which now includes the Compliance Officer's review and confirmation of the verification form. • For each suspected fraud, waste, or abuse case, a verification form will be created, which then will be routed to the Compliance Officer for review & confirmation of next steps. • 2021 Medical Audit did not reveal deficiency in this area. A&I conducted verification studies for appropriate reporting and processing of suspected fraud, waste and abuse cases. The MCP did not have any fraud, waste, or abuse related findings on their 2021 audit report. **The corrective action plan for finding 6.2.2 is accepted.**

Submitted by: Sharron Mackey
Title: Chief Executive Officer

Date: January 25, 2021