MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

December 12, 2022

Marina Owen, CEO
CenCal Health
4050 Calle Real.
Santa Barbara, CA 93110

RE: Department of Health Care Services Medical Audit

Dear Ms. Owen,

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of CenCal Health, a Managed Care Plan (MCP), from October 25, 2021 through November 5, 2021. The audit covered the period of November 1, 2019 through September 30, 2021.

All items have been evaluated and DHCS accepts the MCP's submitted Corrective Action Plan (CAP). The CAP is hereby closed. The enclosed documents will serve as DHCS' final response to the MCP's 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 report and the enclosed documents 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]

Oksana Meyer, MPA
Chief, CAP Compliance & FSR Oversight Section
Managed Care Quality & Monitoring Division
Department of Health Care Services

Enclosures: Attachment A (CAP Response Form)

cc: Lyubov Poonka, Chief
CAP Compliance Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

Christina Viernes, Lead Analyst
CAP Compliance Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

Katryna Fific, Contract Manager
Medi-Cal Managed Care Division
Department of Health Care Services

ATTACHMENT A
Corrective Action Plan Response Form

Plan: CenCal Health **Review Period:** 11/01/2019- 09/30/2021

Audit Type: Medical Audit and State Supported Services **On-site Review:** 10/25/2021 - 11/05/2021

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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. Deficiency Number and Finding, 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 ensure the MCP provides sufficient documentation to correct deficiencies. Depending on the volume and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates, as applicable.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
2. Case Management and Coordination of Care				
2.1.1 - The Plan did not ensure that all required components of IHA were performed and documented.	1. The Plan's new PCP pay-for-performance program, Quality Care Incentive Program (QCIP), is a primary action/intervention to assure increased utilization of recommended USPSTF and AAP preventive care and other medically necessary treatments. These are among the required components of an IHA that PCPs must render to members or refer members to assure their timely receipt. Monthly performance reports will be made available to PCPs via CenCal Health's Provider Portal. This was launched in March 2022 and sample reports are included with referenced attachments. Monthly QCIP Provider Performance Reports are ongoing. https://www.cencalhealth.org/providers/quality-of-care/quality-care-incentive-program/ 2. To assure the completion and documentation of required component IHA services, the	1a. QCIP Performance - Member Detail Report-Compliant 1b. QCIP Performance - Member Detail Report-Non-Compliant (sample reports shared with PCP) 1c. QCIP Performance – Provider Summary Report (sample report shared with PCP)	August 31, 2022	The following additional documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** SOP - IHA Annual MR Audit (IHA and SHA complete with 120 days). Outlines overall IHA completion and Plan monitoring requirements, including documentation requirements on specific behavior-risk topics. **MONITORING & OVERSIGHT** Plan submitted Quality Care Incentive Program Performance (QCIP) reports measuring compliant and non-compliant performance by measure. QCIP Performance Summary Report identifies various performance measures and percentage rates of completion. Identifies top and bottom performers (providers). A summary report called the IHA Provider Performance Report will be generated and used for quality improvement and discussed with providers on a timely basis. IHA Audit Tool templates for Adults and Pediatrics measuring the following: History Physical exam Preventive services

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	Plan will complete an annual IHA medical record review Audit. (July 2022) 3. The Plan will create IHA Audit Provider Performance Reports to illustrate the completeness of required components addressed during an IHA visit. (July 2022) 4. The Plan will meet with providers to provide timely feedback via the IHA Audit Provider Performance Reports, and to communicate expectations and findings of the completeness of IHAs they perform. The Plan will also reiterate the required components of an IHA. (August 2022) 5. The Plan will explicitly communicate the required components of an IHA and the Plan's ongoing monitoring process via the updated Provider Manual as well as through the monthly Provider Bulletin. (August 2022)			Screening assessments SHA IHA Medical Review Guide for Adults and Pediatrics based on the following categories: History Physical exam Preventive services Screening assessments SHA The Plan submitted evidence of self-monitoring, including a sample Quality Performance Report: IHA - MRR Adults Compliance scores for the following components/measures: History Physical exam Preventive services Screening assessments Counseling SHA Overall total Plan submitted revised IHA section of Provider manual, which includes the following: PCP requirements Components SHA Plan monitoring Member outreach, including three documented attempts to contact members.

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				Plan has established a compliance goal of 100% for IHA medical records reviews. Audit results will be shared with various staff in order to further promote increased compliance with medical record documentation. To address the clinic's non-compliance, the Plan presented the IHA Quality Performance Report to the medical leadership of the clinic, with the understanding that the Plan's follow up IHA audit will document IHA improvement and compliance. Per the Plan, the overall results of the follow up review were favorable, except for screening assessments. The Plan will be conducting another follow up review soon to monitor performance improvement. The August Provider Bulletin updates include IHA required components, annual medical record audits (findings shared via Provider Performance reports), and member outreach via provider portal. **The Corrective Action Plan for Finding 2.1.1 is accepted.**
2.1.2 - The Plan did not ensure that a contracted provider addressed some of the critical deficiencies identified in a CAP within the required timeframe.	1. The Plan will ensure adherence to policy and procedures and verify remediation of all critical and non-critical deficiencies cited in an FSR or MRR CAP through the addition of a second level of review. The second reviewer will confirm all deficiencies were	N/A	**Short-Term** August 5, 2022	The following additional documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** Plan revised Policy PS-CR02 Medi-Cal Facility Site & Medical Record Quality Improvement Program (7/28/22). Policy indicates the following:

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	sufficiently addressed and verify completion. The Plan will additionally develop a CAP log for the second reviewer to complete and sign, confirming completion and closure of CAP. 2. The Plan will ensure all critical and non-critical deficiencies identified in an FSR or MRR CAP are addressed within the required timeframe, and that extensions are requested and approved when needed, following established guidelines. This will be accomplished through the addition of a second level of review. The second reviewer will ensure adherence to policy and procedure timelines including those related to critical elements and document this in the CAP log. 3. The Plan also will update Policy & Procedure, "PS-CR02, Medi-Cal Facility Site & Medical Record Quality Improvement Program" providing a Draft to DHCS by August 5, 2022.			• Defines the process for performing initial and subsequent site reviews, consisting of a Facility Site Review (FSR) and a Medical Record Review (MRR) using Department of Health Care Services (DHCS) tools and standards • FSRs ensure that all contracted PCP sites have sufficient capacity to deliver primary health care services while maintaining patient safety standards, and confirms the site operates in compliance with all applicable local, state and federal laws and regulations. • MRRs ensure that medical records meet format requirements and legal protocols, and provide documentation of preventive care, and coordination and continuity of care services. A medical record serves as legal documentation of care rendered to the patient. Without adequate documentation, it cannot be assumed the patient received quality, timely, appropriate care. **MONITORING & OVERSIGHT** A CAP is required for all deficiencies when there is a critical element deficiency or a conditional passing score on either the FSR or MRR, regardless of the type of review. CenCal Health may require a CAP for other findings identified regardless of the site review scores. The site reviewer will offer additional training or technical support if a new PCP site fails the initial FSR. If a prospective site fails the initial FSR on two attempts,

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				the site may reapply after six months. CenCal Health ensures follow-up, closure of CAPs and the monitoring of re-reviews for all site reviews conducted by its staff. All CAPs require documentation of: • The specific deficiency • Corrective actions needed • Projected and actual dates of deficiency correction • Reevaluation of timelines and dates • Responsible persons CAPs for noncritical elements may be verified via submission of documentation, while verification must be done on site for critical elements. Closed CAPs must document: • Any problems encountered in completing corrective actions • Resources and technical assistance provided by CenCal Health • Evidence of the correction • Completion and closure dates • Name and title of the reviewer To ensure timely and thorough completion of CAPs, CenCal Health utilizes a second reviewer to monitor CAP responses, documentation, and timelines for closure. This review may be tracked via a report generated monthly from the Healthy Data System database. Plan has implemented a CAP Log to monitor/track CAP responses, timeliness, requirements and closure dates/timeframes.

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				Email response outlines new process implemented by the Plan in which the Plan informs providers of critical element findings within 24 hours. The second level reviewer is copies on each notification to the providers. All CAPs and their corresponding due dates are tracked via the FSR/MEE CAP Tracking Log. This enables both reviewers to track due dates via Outlook calendars or other notification tools. Prior to the due date, a reminder call/email is sent to the Provider if needed and assistance is offered. Verification of CAP remediation occurs within 30 calendar days via an in-person visit or video conference call. The tracking log is updated when a CAP is issued and a CAP report is generated every 30 calendar days from the HDS system to ensure all data is current and available for timely review of non-critical elements by the second level reviewer. **The Corrective Action Plan for Finding 2.1.2 is accepted.**
2.3.1 - The plan failed to inform members, or their families/primary caregivers, about EPSDT, BHT, services and how to obtain these services and the necessary scheduling assistance available.	1. The Plan has revised Behavioral Health Therapy (BHT) policy, HS-BH300 to include a section that outlines member education and the methods available to inform members of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and BHT services. Kindly reference: **HS-BH300** 2. Operationally the Plan will	1. HS-BH300; Behavioral Health Treatment (BHT) Draft Page Number: 3 Revision Date: July 1, 2022	August 1, 2022	The following additional documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** - HS-BH300 Behavioral Health Therapy Draft was revised (7/1/22) to include section to describe the methods of informing members about EPSDT and BHT Services. (page 3) - September Member Newsletter Draft informs members of BHT services and how to obtain them.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	inform members about EPSDT, BHT, services and how to obtain these benefits through: Upon calling in to the Behavioral Health (BH) Call Center or Member Services Department and requesting information (August 1, 2022) Member Handbook/ Evidence of Coverage (EOC) (effective 1/1/2023) CenCal Health's website: https://www.cencalhealth.org/members/behavioral-health/Behavioral Health page (August 1, 2022) Member Newsletter (next release September 2022)			- Behavioral Health Cal Center Script instructing staff providing information on BHT services. - Website Revision provides information on eligibility for and on how to obtain BHT services. - Department Training Log for BHT Education from 7/25/22 demonstrates MCP has trained staff on how members may access BHT services. **The Corrective Action Plan for Finding 2.3.1 is accepted.**
2.3.2 - The plan failed to ensure that all BHT files had a treatment plan that met all criteria including identification of measurable long, intermediate and short-term goals.	1. The Plan elected to terminate its relationship with The Holman Group as a Utilization Management delegate, effective 12/31/2021. The Plan now directly administers and oversees Behavior Health and Mental Health benefits. 2. The Plan is closely overseeing	1. Policy HS-BH300; Behavioral Health Treatment (BHT) Draft Page Number: 5 Revision Date: 7/1/2022	August 1, 2022	The following additional documentation supports the MCP's efforts to correct this finding: **POLICY & PROCEDURES** - HS-BH300 Behavioral Health Therapy Draft was revised (7/1/22) to ensure treatment plans Identify documented measurable long, intermediate, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant and based upon clinical observation.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	the administration of the benefit, including Utilization Management (UM) to ensure treatment plans meet criteria and identifies measurable goals, including long, intermediate, and short-term. This has been revised in Behavioral Health Treatment Policy, **HS-BH300**, Section (C)(c)iv. 3. Staff training will be conducted and documented during the month of July 2022.			**MONITORING & OVERSIGHT** - The MCP's Behavioral Health department will complete monthly audits to ensure treatment plans meet the requirements as outlined in APL 19-014. - 8/15/22 – 9/15/22 BHT Audit results demonstrate the MCP conducts BHT blind peer audits of BHT files on a monthly basis. **TRAINING** - BHUM Training from 7/18/22 demonstrates the MCP has trained its staff on Medi-Cal standards for BHT Treatment Plans including short term, intermediate and long-term goals. - Department Training Log demonstrates MCP conducted training on BHT treatment plan requirements as planned. **The Corrective Action Plan for Finding 2.3.2 is accepted.**
2.4.1 - The Plan did not notify members 30 calendar days before the end of COC period.	The Plan has organized a cross departmental workgroup to address CAP finding 2.4.1. This workgroup will address the following: 1. The Plan will create a Continuity of Care (CoC) workflow diagram that	N/A	October 1, 2022	The following additional documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** Policy MM-UM08 Continuity of Care (7/29/22) CenCal Health notifies the member via written notification letter 30 calendar days before the end of the continuity of care period about

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	incorporates updated Member Services (MS), Utilization Management (UM), Case Management (CM), and Provider Services (PS) aspects and includes CoC timeframes and All Plan Letter (APL) requirements. The Plan will update internal Policy & Procedure document accordingly. (August 1, 2022) 2. The Plan will create templated CoC Notice of Action (NOA) letters which include all CoC provisions and ensure they are sent within the required 30 days to members informing them of the COC process. Templated letters will be submitted to DHCS for approval. (August 1, 2022) 3. The Plan will create training materials for staff. (September 1, 2022) 4. The Plan will educate on the new process to MS, UM, CM, PS staff. (October 1, 2022) 5. The Plan will create internal			the process that will occur to transition his or her care at the end of the continuity of care period. This process includes engaging with the member and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider. CenCal Health will utilize continuity of care reports to track continuity of care end period and ensure timely written notification to the member. COC Notification template letters – Approval and Notification Period Ending were developed and submitted to MCOD for review and approval. Approval obtained 10/26/22. **MONITORING & OVERSIGHT** The Plan developed and deployed a weekly COC Authorization Notification monitoring report effective 10/1/2022. The Plan provided evidence of the report template that provides data elements captured for monitoring of members approaching the COC ending period. **TRAINING** PowerPoint training materials for Behavioral Health, Member Services, Provider Services, Utilization Management. Training covered CoC overview, APL review, CoC process/workflow, UM role in CoC, CM role in CoC, P&P, Letter Process Evidence of staff training sign in sheets.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	reports to ensure COC provisions are tracked and Turn-Around Times (TATs). (October 1, 2022)			**The Corrective Action Plan for Finding 2.4.1 is accepted.**
3. Access and Availability of Care				
3.8.1 - The Plan did not ensure that its NEMT and NMT subcontractors or vendors were enrolled in the Medi-Cal program.	1. The Plan will ensure that all subcontractors employed by its Transportation Broker are enrolled in the Medi-Cal program 2. The Plan notified its Transportation Broker on 3/02/2022 of this requirement and the Broker subsequently ensured all subcontractors initiated the enrollment process. The Plan will ensure enrollment is completed within 120 days. 3. The Plan will add or clarify language in existing and future contracts and delegation agreements to ensure providers, vendors and brokers understand this requirement. 4. The Plan's Transportation Broker will be required to submit a roster of subcontractors quarterly and when changes	N/A	August 1, 2022	The following additional documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** • MM-UM 33 NEMT & NMT ○ The Plan updated its P&P "MM-UM 33 NEMT & NMT" to address the gap that contributed to the deficiency. (Approved by MCOD 09/27/22) The Plan will monitor enrollment of transportation providers on a quarterly basis to ensure that they are complying with the requirements set forth in the APL 22-008; including imposing corrective action if non-compliance is identified. (MM-UM 33, III.E.e., page 7) The Plan produced evidence of revised documents to demonstrate implementation: • Transportation Broker's Contract Amendment "VTS Amendment Three 5.2020" requires the broker to use only enrolled subcontractors. (Exhibit G: Delegation Agreement, Section 3, Responsibilities of Contractor) • Transportation Broker's Vendor Roster "VTS Provider Roster_10.2022" demonstrates the monitoring of 120-day compliance. **OVERSIGHT & MONITORING**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	occur. 5. The Plan will monitor and verify enrollment of all the Transportation Broker's subcontractors via the annual assessment and track this through the quarterly Delegation Oversight Committee.			• MM-UM 33 NEMT & NMT ○ The Plan oversees enrollment with a quarterly roster presented by VTS (VTS Provider Roster_10.2022). To address the deficiency, the Plan will request an updated roster each month, until review of pending applications by DHCS is complete. If DHCS denies an application or 120 days is exceeded, the Plan will advise and collaborate with VTS to remove the subcontractor within 15 calendar days from the network from said date. The Plan will immediately work with DHCS on a transition plan, if the termination results in network deficiencies and member access issues. Once all pending applications are resolved, the Plan will shift from monthly monitoring to quarterly monitoring and the process will continue to be overseen by the Delegation Oversight Committee (DOC). VTS understands the contractual obligations to notify the Plan when a new subcontractor is added to the network. This notification ensures the Plan to monitor the enrollment status and completion within required timeframe. • DOC Meeting Agenda ○ The agenda demonstrates the Plan has added VTS subcontractors as an agenda item at the DOC meeting as part of its oversight & monitoring efforts. (DOC Agenda_July 2022) **The Corrective Action Plan for Finding 3.8.1 is accepted.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
4. Member Rights”				
4.1.1 - The Plan incorrectly classified call inquiries as exempt grievances.	1. The member billing call inquiries will no longer be auto defaulted by the Plan’s call coding classification as exempt grievances. The Plan has updated and implemented policy and procedures to ensure that grievances are classified as a standard grievance if not resolved by the next business day. Kindly reference: 1. **MS-20_Draft**	1. MS-20_Grievance & Appeals System Draft Redline Page Number: 5 Revision Date: June 7, 2022	July 1, 2022	The following additional documentation supports the MCP’s efforts to correct this finding: **POLICIES & PROCEDURES** Updated Policy MS-20 Member Grievance and Appeals System indicates, the Grievance & Appeals, Quality Improvement Manager reviews the call inquiries that are received via CenCal Health’s Call Center and classified as “Exempt Grievances” by the Member Services Representatives. The Grievance & Appeals, Quality improvement Manager, regularly reviews these classified exempt grievances to ensure accuracy of coding. This coding change will occur as determined necessary by the Grievance & Appeals, Quality Improvement Manager, and if determined a standard grievance is now required, the process for standard grievance and appeal classification is followed. The Plan’s Grievance Team sends every case classification for approval to the Medical Management Teams Nurse Reviewer, who agrees or disagrees with the classification. Changes to coding are made if disagreed upon following the suggestion of the Nurse Reviewer. **MONITORING & OVERSIGHT** Standard Operating Procedure “MSSOP-059 – Call Tracking and Ticketing.” Language was added to clarify the weekly review and oversight by the Call Center leadership, reviewing MSR call

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				classifications by key word search in call tracking ticket notes that would normally relate to grievances. When identified leadership would speak with the MSRs regarding QI opportunities for mitigation of incorrect classification/documentation. Key components - Should any “key” or “trigger” words be inserted in the notes section which would indicate that an Appeal or Grievance should have been started/offered, a customized report will be run on a weekly basis which will search for these “trigger” words. This weekly review will further bolster G&A compliance. Some examples of these “trigger” words would be “angry,” “upset,” “denied,” “complaining,” etc. Each Supervisor/Manager will review this weekly report for their respective teams to make sure an Appeal or Grievance was started, or it was documented in notes that the caller refused or did not want to move forward with the formal process. "MS All-Staff Meeting Minutes 6-24-2022" after the Call tracking coding classification change was implemented and was ready to share with the team. The Plan addresses improper classification of exempt grievances directly with staff when/if identified by the Grievance& Appeals Manager and/or the Member Services Call Center Supervisors and Manager. **The Corrective Action Plan for Finding 4.1.1 is accepted.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
4.1.2 - The Plan's QOC Grievance Resolution Letters did not address all grievance issues. The Plan's Policy and Procedure MS-20, Member Grievance and Appeals System (revised 10/02/2020), did not include a procedure to address grievances with multiple issues.	1. The Plan has developed and implemented policy and procedures ensuring all issues outlined within a grievance are addressed and resolved. These results are then documented within the Grievance resolution Letters. Kindly reference: 1. **MS-20_Draft**	1. MS-20_Grievance & Appeals System Draft Redline Page Number: 10 Revision Date: June 7, 2022	July 7, 2022	The following additional documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** Plan Policy MS-20 Member Grievance and Appeals System (8/11/22) Policy has been revised to include procedures to ensure all grievances resolution letters address all issues; including: The Member Services Grievance & Appeals Coordinator notifies members, in writing that CenCal Health has finished its review of their grievance or appeal no later than thirty (30) calendar days from its receipt. CenCal Health has 30 calendar days to resolve appeals regardless of whether the oral appeal is followed by a written appeal. The Grievance Manager also reviews all final letters prepared by the Grievance Coordinators to ensure all aspects of the grievance are addressed as applicable in the final documentation to the member or their representative. Review and approval of final letter documentation occurs for the non-clinical and clinical review cases. **MONITORING & OVERSIGHT** Plan has implemented a process to review all clinical grievance letters as done with the non-clinical letters, to ensure staff are

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				inserting information into the clinical letter and addressing all non-clinical issues. This process checkpoint was added to the Grievance Manager File Audit Checklist self-attestation. Complaints/Appeals/Attestation Audit Checklist - Includes review to ensure all investigation addresses all aspects of member concerns. - Includes review of proper routing for clinical and non-clinical issues. - Final resolution letters are reviewed by Grievance Manager to ensure all clinical/non-clinical issues are addressed prior to mailing. Plan provided evidence of Grievance file-audit checklist. As part of oversight process, Grievance and Appeals manager will work directly with Grievance Coordinators if any missing information is excluded from resolution letters. Audit checklist cannot be completed without manager review. Grievance managers hold weekly meetings with Grievance Coordinators to identify and discuss trends and QI opportunities for process improvement. **The Corrective Action Plan for Finding 4.1.2 is accepted.**

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4.2.1 - The Plan's policy and procedure did not include linguistic proficiency and capability passing requirement.	1. The Plan has updated two policy and procedures to include language addressing the linguistic proficiency and capability passing requirement. These updates include the required qualification, and or passing score that staff must meet to provide linguistic service to members for overall assessing and monitoring. Kindly reference: **1a. MS-30_Draft** **1b. MS-31_ Draft**	1a. MS-30_Translation of Written Materials Draft Page Number: 3 Revision Date: July 1, 2022 1b. MS-31_Cultural & Language Access Program Draft Page Number: 3 Revision Date: July 1, 2022	July 1, 2022	The following additional documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** Plan has updated P&Ps to address the gap that contributed to this audit finding, including detailing the required qualifications and passing scores needed for staff to be able to provide linguistic services to members. Policy MS-30 Translation of Written Member Materials (7/1/22) Plan has established an internal document translation process that include designated staff members who translate member materials into the threshold language. Plan utilizes an outside qualified State of California certified evaluator who has attested to the competency of the team member's written skills. Translated documents are reviewed for: • Accuracy of translation • Appropriate grammar, syntax • Cultural appropriateness • Culturally transposition of translated document • Readability • Clarity and conciseness of translation, literacy level Plan policy requires 80% or higher on language assessment in order to provide written or verbal translation.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				Policy MS-31 Cultural and Language Access to Service (7/1/22) • Plan staffs Member Services Department with bi-lingual/bi-cultural staff in Plan's threshold language (Spanish) • Plan created a formal process of evaluating competency of bi-lingual staff. • Plan contracts with a telephonic interpreter vendor to provide interpreter services 24/7. • Plan validates the proficiency of bilingual staff and contracted interpreters to establish competency and ensure information is communicated accurately. • A formal evaluation process and tool to test and evaluate the capacity of bi-lingual staff. The Plan contracts with an outside evaluator to assess the following: • Oral fluency and expression • Listening • Comprehension • Health care vocabulary Staff must score 80% or higher on their certified language assessment for verbal and written Spanish to translate for the Plan. **MONITORING & OVERSIGHT** The Plan has established policies and procedures that outline the requirements for bi-lingual staff to translate for the Plan. Plan policies include a formal evaluation process that evaluates the capability and proficiency of bi-lingual staff, who must achieve a

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				minimum scoring target in order to be certified. The Plan utilizes a qualified vendor to evaluate and assess the competency of bi-lingual staff translation and interpretation skills. Staff must pass a language assessment to provide written or verbal translation. The Plan's Director and Call Center leadership ensure staff not yet assessed or staff assessed but did not receive a passing score, cannot participate in the Spanish phone queue or on the company's Written Translation Team. Additionally, the Plan's Member Services C&L Resource Coordinator and/or Member Services Director forward all approved assessments to the Human Resources Department for initiation of a stipend after staff pass their assessment. This process ensures only those staff that are certified to participate in the bilingual phone queue and written translation team functions for the Plan, receive compensation for this added ability. **The Corrective Action Plan for Finding 4.2.1 is accepted.**
5. Quality Management				
5.1.1 - The Plan did not have a health practitioner/ contracting physician available 24/7 to coordinate post ER stabilized patients.	1. The Plan will develop an on-call calendar, designating a health plan practitioner or contracted physician to be available 24/7 (August 15, 2022) 2. Development of "new" Post	2. MM-TBD: After-Hours Availability of Plan or Contract Physician_Draft Effective Date: September 1, 2022	September 1, 2022	The following additional documentation supports the MCP's efforts to correct this finding: **POLICY & PROCEDURES** - Updated P&P, "MM-TBD: After-Hours Availability of Plan or Contract Physician" which states that, For afterhours, weekend, and

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	Stabilization policy Draft. Kindly reference: **2. MM-TBD: After-Hours Availability of Plan or Contract Physician_Draft** (September 1, 2022) 3. Development of letter to mail/fax annually to all California Non-contracted Hospitals instructing providers of the Plan's Post stabilization process-first notification (August 15, 2022)			holiday approvals the provider should contact the on-call CenCal Medical Director at (XXX) XXX-XXXX (MM-TBD_Policy Draft, Page 3). - "Medical Directors After Hours and On-Call Schedule" (Q3/Q4 2022 and 2023) as evidence that the MCP has developed an on-call calendar, designating a health plan practitioner or contracted physician to be available 24/7. The on-call calendar lists the scheduled medical director's name to be on call after hours, weekends, and holidays for each month (Medical Director After Hours and On-Call Schedule for 2022, Medical Director After Hours and On-Call Schedule for 2023). - "Notification Letter to OON Hospitals" (08/15/22) in which the MCP has developed a letter to mail/fax annually to all California Non-contracted Hospitals instructing providers of the Plan's Post stabilization process-first notification. The letter mentions the following: Effective 9/1/22 if a CenCal Health member in your care has an emergency medical condition (as defined by Health & Safety Code 1317.1(b)) and needs post-stabilization care, including a psychiatric emergency medical condition (as defined by Health & Safety Code 1317.1(k)) requiring a transfer for admission to a hospital psychiatric unit or acute psychiatric hospital for care or treatment necessary to relieve or eliminate a psychiatric emergency medical condition, it is requested that the attending physician/hospital meet the following obligations: • Notify the PCP immediately.

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				• For requests for post stabilization care or a transfer for admission to relieve or eliminate a psychiatric emergency medical condition: o During business hours contact CenCal Health at 805-562-1082 and follow the prompts or call 800-421-2560, select option 1 then option 2 and follow the prompts. o For after-hours contact the on-call CenCal Health medical director at 805- 562-1082 and follow the prompts or call 800-421-2560, select option 1 then option 2 and follow the prompts. Pursuant to Health & Safety Code section 1262.8 (d)(2) and Title 28 CCR Section 1300.71.4 (b)(2), upon receipt of a post-stabilization authorization request from an emergency services provider, CenCal Health will render a decision within 30 minutes, or the request is deemed approved. (Notification letter to OON hospitals_FINAL 8 11 22) **MONITORING & IMPLEMENTATION** - An email (08/24/22) in which the MCP confirmed that the process is the same for both in-network and out-of-network providers for post-stabilization care. The MCP also notified their in-network providers of this information. The MCP included an itemized mailing list of providers. The notice was mailed on August 13, 2022 (CAP 5.1.1 Hospital Mailing 08132022). **The Corrective Action Plan for Finding 5.1.1 is accepted.**

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6. Administrative and Organizational Capacity				
6.2.1 - The Plan did not have policies and procedures to verify that services that have been represented to have been delivered by network providers were received by members.	1. The Plan updated policy "CPL-41 FWA Intake, Investigation and Reporting" and added medical records review process. Kindly reference: **1. CPL-41_Draft**	1. CPL-41 FWA Intake, Investigation and Reporting Draft Revision Date: June 24, 2022 Page Number: 2-3	June 24, 2022	The following additional documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** - Updated P&P, "CPL-41: FWA Intake, Investigation and Reporting" (06/24/22) which states that, During the investigation process, CenCal may verify whether services that have been represented to have been delivered by a Healthcare Provider were received by members. During such verification, the Healthcare Provider is asked to allow CenCal access to the medical record and billing documents that support the charges billed. CenCal verifies through medical records review whether services that have been represented to have been delivered by Healthcare Providers were received by Members. The verification of services is conducted on a regular basis by various departments in CenCal through facility site reviews, quality of care of investigations, and HEDIS audit. In the event that the Healthcare Provider does not submit or refuses to provide a medical record, Provider may receive a denial or a request for recovery of payment (CPL-41_Draft, Page 2). - Written response from the MCP (10/26/22) in which the MCP received an allegation that the provider is billing for tests that is not performed. The MCP conducted a sample review of 30 hemoglobin A1c tests through review of medical records. **MONITORING & OVERSIGHT**

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				- Excel Spreadsheets, “Compliance 20-14 Member Outreach” (10/26/22) and “Compliance 22-02 (F) Lags Member Outreach” which demonstrates that the MCP has contacted members to confirm that member received services from the provider. The MCP tracks the following: Date of Service (DOS), Member Name, Member Recalls Receiving and Services on DOS (Y/N), Services Received During Visit, Member Comments, Date and Time of Call/Attempt (Compliance 20-14 Dawoom Member Outreach, Compliance 22-02(F) Lags Member Outreach). - “IHA Quality Reports” (11/15/22) which demonstrates that the MCP conducts an annual medical record review audit of completed IHAs for selected high-volume providers. This annual audit is a proactive method used by the MCP to assure that services reported for reimbursement are indeed received by members, and it is not prompted because of suspected fraud, waste, or abuse. The annual audit initiated in July 2022 demonstrated 100% agreement between services billed and documented in sampled members medical records. The medical record review of 300 medical records was performed to assess the documented completion of a comprehensive preventive medicine evaluation. In addition, the MCP’s Health Claims Support Team – Quality Assurance Team performs quality audits on claims to determine if payments are consistent with provider agreements with the MCP. The Quality Assurance Team performs random sample audits and analysis on claims to ensure that all department policies and regulatory requirements have been met. The Quality Assurance

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				Team identifies and reports all possible problems to the appropriate staff for necessary corrections and improvements can be made. Any suspected FWA cases are referred to Compliance. (CM_IHA Quality Reports, CM_IHA MRR Tool – Adults, CM_IHA MRR Tool – Peds) **TRAINING** - Meeting Agenda, “Anti-Fraud Committee” (11/08/22) which demonstrates that the MCP had a discussion to review the audit results (November 2022 AFC Agenda_Draft). **The Corrective Action Plan for Finding 6.2.1 is accepted.**

Submitted by: [Plan’s Signature on File] **Date: July 7, 2022**
Title: Marina Owen, CEO