ATTACHMENT A
Corrective Action Plan Response Form

Plan Name: CenCal Health

Review/Audit Type: DHCS A&I Medical Review Audit **Review Period:** August 1, 2013 - July 31, 2014

MCPs are required to provide a CAP and respond to all documented deficiencies within 30 calendar days, unless an alternative timeframe is indicated in the letter. MCPs are required to submit the CAP via email in word format which will reduce turnaround time for DHCS to complete its review.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. For deficiencies that require long term corrective action or a period of time longer than 30 days to remedy or operationalize, the MCP must demonstrate it has taken remedial action and is making progress toward achieving an acceptable level of compliance. The MCP will be required to include the date when full compliance is expected to be achieved.

DHCS will maintain close communication with the MCP throughout the CAP process and provide technical assistance to ensure the MCP provides sufficient documentation to correct deficiencies. Depending on the volume and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates, as applicable.

CORRECTIVE ACTION PLAN FORMAT

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
1. Utilization Management				
1.2.1 One (1) out of 23 pharmacy services did not meet the 24-hour turnaround time frame. The denial was decided in two business days instead of 24 hours or one business day as according				Note: This deficiency involves only one pharmacy authorization. The MCP is encouraged to take the necessary steps to ensure the 24-hour timeframe is met. **This deficiency is closed.**

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to Contract requirements.				
1.2.2 The Plan's Policy failed to include specific language on timeframes for authorizations as stated in the Contract. The Contract stipulates for prior authorization, "Pharmaceuticals: 24 hours or one (1) business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1)." [COHS Contract Reference: Exhibit A.5.3.F]	The Plan's policy, Prospective MRF Denial Process, will be amended to specify the 24 hour or one business day timeframe.	Prospective MRF Denial Process document	Immediately	DHCS recommends that the Plan amend Policy to assure that the required Pharmacy approval or denial timeframes as described in the Contract are also included in the applicable Policy and Procedure. The Plan submitted its UM description which was updated to specify the 24 hour or one business day time frame. **This item is closed.**
2. Case Management and Coordination of Care				
2.1.1 Plan Policy fails to include language describing that Case Management Services are delivered within and outside of the Plan's network	1. Policy 400-2014-C, Care Management Planning and Coordination has been updated to reflect care management services are available for members accessing out of plan services.	Policy 400-2014-C, Care Management Planning and Coordination	June 20, 2015 July 10, 2015	DHCS recommends that the Plan amend Policy to ensure the required Case Management covered services as described in the Contract are also included in the applicable Policy and Procedure. The Plan submitted Policy 400-2014-C that includes language that care management services

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	2. During next staff meeting, re-educate staff and distribute updated policy.			are available for members accessing out of plan services. **This item is closed**
2.4.1 Thirty-four (34) medical records were reviewed to ascertain IHA completion. Out of 34 medical records, four (4) medical records exceeded the time frame to perform the IHA and 2 (two) medical records did not have a comprehensive assessment required of an IHA.	1. The Plan will re-inform its Primary Care Providers of the IHA requirement and expectation that they outreach to new members to complete their IHAs within 120 days of receipt of Medi-Cal eligibility. 2. The Plan will offer an appropriate gift card incentive to each new member that complete an IHA within 120 days of receipt of their Medi-Cal eligibility. 3. The Plan will offer financial incentives to PCPs and OB/GYNs that complete IHAs for adult new Medicaid Expansion members within 120 days of receipt of Medi-Cal eligibility. 4. The Plan will continue to offer financial incentives to PCPs for completion of Preventive Medicine Evaluations.		On or before July 30, 2015. On or before July 30, 2015. July 1, 2015, with payments beginning in August 2015. In process and continuing	DHCS recommends that the Plan enhance quality controls to ensure that Providers complete the Individual Health Assessment for all new Members within the timelines stipulated in the Contract. **This item is provisionally closed.** Please submit communication with Primary Care Providers re-enforcing the IHA requirement and expectation that they outreach to new members to complete their IHAs within 120 days of receipt of Medi-Cal eligibility.
3. Access and Availability of Care				
3.1.1 The Plan did not monitor waiting times to obtain the initial prenatal care appointment.	The Plan will conduct a survey to include the following question: "When is the next available appointment date* and time for a pre-natal care		December 31st, 2015	DHCS recommends that the Plan develop and implement monitoring procedures to ensure that prenatal care visits meet access standards as required by the Contract.

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	appointment (Standard: 10 business days)? *first available Practitioner, surveying one from each county/per group) The Plan will monitor prenatal care appointments through the results of this survey, and oversight will occur by reporting through the quality committee structure as described in the Plan's Quality Assessment and Improvement Program.			The Plan will conduct a survey to monitor wait times for the initial prenatal care appointment. The results of the survey will be reported through the quality committee structure. **This item is provisionally closed.** Please submit the survey when completed.
3.1.2 The Plan did not monitor waiting times in Providers' offices during the audit period	The Plan will modify the survey design of its provider appointment availability survey to include the following question: "What was the average total wait time, from our member's scheduled appointment time (not the time the member arrived) until the member saw the provider (not when the member got roomed)?" The Plan will monitor prenatal care appointments through the results of this survey, and oversight will occur by reporting through the quality committee structure as described in the Plan's Quality Assessment and Improvement Program.		December 31st, 2015	DHCS recommends that the Plan develop and implement a procedure to monitor waiting time in Provider offices. **This item is provisionally closed.** Please submit the revamped survey when completed.

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3.5.1 Specific language related to processing and paying claims in a timely manner for services rendered should be included in the existing Policy to comply with California Code of Regulations, Title 28, section 1300.71(g).	The Plan's Policy, Payment of Emergency and Urgent Services, (800-2000-C) will be amended to include a stipulation that complete claims be reimbursed within thirty (30) working days after the date of receipt.	Policy 800-2000-C, Payment of Emergency and Urgent Services	Immediately	DHCS recommends that the Plan Update Policy, Payment of Emergency and Urgent Services, (800-2000-C) to include a stipulation that complete claims be reimbursed within thirty (30) working days after the date of receipt. The Plan submitted the updated Policy 800-2000-C which includes language stipulating that complete claims be reimbursed within thirty (30) working days after the date of receipt**. This item is closed.**
3.7.1 During the audit period, the Plan did not monitor any emergency providers to ensure Members were provided an emergency provision of prescribed drugs.	The Plan's Policy "Credentialing of Organizational Providers" will be amended to require the submission of ED protocols concerning dispensing of outpatient medications, as part of the annual credentialing process. In addition, the Chair of the Delegation Oversight Committee, on a quarterly basis will report to the Plan's Healthcare Operations Committee (which reports to the Plan's quality oversight committee, the Quality Improvement Committee) the adequacy of 24 hour and extended hour pharmacy access within the Plan's PBM's contracted network of pharmacies.	Policy 500-2007-D, Credentialing of Organizational Providers	Immediately	DHCS recommends that the Plan develop policies and procedures for monitoring to ensure the provision of prescribed drugs in emergency circumstances. The Plan updated Policy 500-2007-D to include language requiring the submission of ED protocols concerning dispensing of outpatient medications, as part of the annual credentialing process. **This item is closed.**

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4. Members' Rights				
4.3.1 The Plan provided the HIPAA Privacy Incident Log for the audit period with two incidents listed. The Incident Summary Reports revealed that the Plan does not report "suspected" or "potential" breaches to DHCS as the Contract requires. [COHS Contract Reference: Exhibit G.3.H.1]	The Plan's Privacy Breach report protocols for incidents that are "potential" or "suspected" HIPAA breaches have been amended to clarify that submission of every incident will take place within the mandated time frame, to the appropriate agencies.		Immediately	DHCS recommends that the Plan enhance quality controls to ensure notification to DHCS of actual and suspected security incident, intrusion or unauthorized use or disclosure of protected health information or potential loss of confidential data within the required timeframe as stipulated in Plan's policies and the DHCS Contract and to all required DHCS personnel. The Plan submitted its updated Health Privacy Program which clarifies potential and suspected incidents will be submitted to the appropriate agencies within the mandated timeframe. **This item is closed.**
4.3.2 The Contract requires the Plan to notify DHCS of the elements of the breach within five (5) working days of the discovery. However, the Plan's Policy does not include this statement. [COHS Contract Reference: Exhibit G.3.H.2]	The Plan's Privacy Breach report protocols have been amended to include the five (5) working day requirement.		Immediately	DHCS recommends that the Plan update Policy to include language regarding notifying DHCS of the elements of the breach within five (5) working days of the discovery of the breach. The Plan updated its Health Privacy to include the privacy breach reporting timeframes specified in the contract. **This item is closed.**

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5. Quality Management				
5.5.1 Twenty-five (25) of thirty four (34) medical records reviewed were missing elements of a complete medical record. In some instances, there was no documentation of a complete record of immunizations, health maintenance, or preventative services rendered. [COHS Contract Reference: Exhibit A.4.13.D]	To promote preventive care services, the Plan will re-inform its Primary Care Providers of the IHA requirement and expectation that they outreach to new members to complete their IHAs within 120 days of receipt of Medi-Cal eligibility. The Plan will offer an appropriate gift card incentive to each new member that complete an IHA within 120 days of receipt of their Medi-Cal eligibility. The Plan will offer financial incentives to PCPs and OB/GYNs that complete IHAs for adult new Medicaid Expansion members within 120 days of receipt of Medi-Cal eligibility. The Plan will continue to offer financial incentives to PCPs for completion of Preventive Medicine Evaluations. The Plan will perform a quarterly retrospective analysis of claims data, and generate quarterly reports to identify common areas of deficiency		On or before July 30, 2015. On or before July 30, 2015. To be effective on July 1, 2015, with payments beginning in August 2015. In process and continuing On or before July 30, 2015.	DHCS recommends that the Plan enhance quality controls to ensure that a complete medical record is maintained for each Member. The Plan submitted a provider bulletin on improving medical records documentation. The bulletin stresses the importance of completing the Staying Healthy Assessment (SHA), TB screening and assessing child and adult immunization status. The Plan will augment its Facility Site Review monitoring system to include a review of medical record sufficiency. **This item is closed**

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	with network providers. Areas with lowest performance (SHA, TB testing, Immunizations) will be reported each quarter in the Provider Bulletin with tips to improve medical record documentation. Finally, the Plan will augment its Facility Site Review monitoring system to include an interim (annual) review of medical record review sufficiency.		On or before July 30, 2015.	
5.6.1 The Plan does not have policies and procedures for the criteria and eligibility of sterilization procedures. The Plan also lacks policies and procedures regarding Provider requirements in obtaining sterilization consent forms for designated procedures prior to performing sterilization procedures. Additionally, there are no policies and procedures giving specific instructions for the completion of the sterilization consent form (PM 330). Furthermore, there are no policies in place to educate Member of the full access to Family Planning Services and the		Provider manual with informed consent instructions		DHCS recommends that the Plan Develop Policies and Procedures regarding the Informed Consent process and the documentation requirements with specific instructions for the completion of the sterilization form. The Plan submitted instructions for Informed Consent located in the Provider Manual. **This item is closed.**

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right to choose and access a qualified Family Planning Provider without prior authorization. [COHS Contract Reference: Exhibit A.4.13.D.7 and A.9.8.A.1]				
6. Administrative and Organizational Capacity				
6.5.1 The Plan reported five (5) fraud and abuse cases to the DHCS within the timeframe of ten (10) working days to comply with contractual requirements; however, four (4) suspected fraud and abuse cases were not reported at all. [COHS Contract Reference: Exhibit E.2.24.B.1]		FWA Worksheets for three members		DHCS recommends that the Plan enhance quality controls to ensure that all cases of suspected fraud and abuse are reported to the Department of Health Care Services within the required timeframe of ten (10) working days. **This item is closed.** Please continue to send suspected cases of fraud and abuse that meet the Plan's threshold of suspected fraud to DHCS within 10 days.

Submitted by: Rebecca Hudson **Date:**
Title: Sr. Compliance Coordinator