State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

May 19, 2021

Frank Lee, Director of Compliance and Government Relations
Contra Costa Health Plan
595 Center Avenue, Suite 100
Martinez, CA 94553

RE: Department of Health Care Services Medical Audit

Dear Mr. Lee:

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 April 8, 2019 through April 19, 2019. The audit covered the period of June 1, 2018 through March 31, 2019.

On May 14, 2021, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on September 19, 2019.

All items have been evaluated and DHCS accepts the MCP's submitted CAP. The CAP is hereby closed. Overall effectiveness of the CAP will continue to be assessed, as well as, to what extent the MCP has operationalized proposed corrective actions on the subsequent audit. The enclosed report will serve as DHCS' final response to the MCP's CAP.

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

If you have any questions, feel free to contact me at (916) 345-7829 or Anthony Martinez at (916) 345-7828.

Sincerely,

Michael Pank, Chief
Compliance Unit

Enclosures: Attachment A, CAP Response Form

cc: Jennifer Maryland, Contract Manager
Department of Health Care Services
Medi-Cal Managed Care Division
P.O. Box 997413, MS 4408
Sacramento, CA 95899-7413

ATTACHMENT A
Corrective Action Plan Response Form

Plan: Contra Costa Health Plan **Review Period: 06/01/18 – 03/31/19**

Audit Type: Medical Audit and State Supported Services **Onsite Review: 04/08/19 – 04/19/19**

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 in word format that 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 short-term corrective action, implementation should be completed within 30 calendar days. For deficiencies that require long-term corrective action or a period longer than 30 calendar days for implementation, 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. **Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval in accordance with existing requirements.**

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
1. Utilization Management				
1.1.1 Develop and implement policies and procedures to ensure that UM	1.1.1 The UM Dept. has reported in the past and continues to report to the Quality Council on a quarterly basis to present the following	1.1.1 QC Reporting Schedule 1.1.1 Revised	**January 2020**	**10/21/19** - The following documentation supports the MCP's efforts to correct this finding: - Updated P & P, Utilization

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activities are integrated into the quality improvement system.	reports: 1. The Under/Over Utilization Report. This report will be modified to include Analysis, Actions Completed, and Action Plan 2. The Authorization Turnaround Time Statistics Report, which includes the Denials, Deferrals, and Modifications report is now separated into (2) reports: a. The Authorization Turnaround Time Statistics Report and b. The AGD Report (Authorization Denial(s) and Modification Report Both reports will be modified to include Analysis, Actions Completed, and Action Plan	Program Description		Management Program Description (02/8/2019) which has been amended to include a review of UM reports will take place on the 1st of the month of each quarter. The UM Committee will be responsible for reviewing these reports on the 2nd month of the quarter. After the review process is completed the data will be presented to the Quality Council on the 1st month of the following quarter. **10/28/19** - The following additional documentation supports the MCP's subsequent efforts to correct this finding: - Revised sample report, Q2 2017 Over Utilization, as evidence of the structure of the Over, Under-utilization reports that will be released quarterly for review and presentation purposes. The report analyzes the ten most utilized codes by quarter. Modifications have been made to the report to include, analysis, actions completed and action

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	3. IRR (Inter Rater Reliability) administered by the by the UM Manager to include all results of all clinical staff 4. Minutes of UM committee including reference to review of quarterly delegate reports. 5. Appeals activity report reated to enable UM/CCHP to have a detailed analysis and decision and the action plan/report will allow Quality Council staff to fully understand the analysis of appeals activity.			plans. Over and Under-utilization reports will be documented in the Quality Council meeting minutes going forward. **This finding is closed.**

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1.1.2 Develop and implement comprehensive and systematic methods for detecting under- and over-utilization of services throughout the Plan, including comparisons (benchmarking) of utilization patterns to other similar organizations.	1.1.2 The UM Dept.is implementing a change to the Over and Under Utilization Report. This report will be modified to include Analysis, Actions Completed, and Action Plan. This report will also include comparison to local benchmarks. CCHP/UM. has met the same standards for benchmarking as local and regional health plans. UM Manager met with similar local health plans and is in process of collaborating with them regarding benchmarking.	1.1.2 UM15.008 Tracking Over and Under Utilization Report	**September 15, 2019**	**10/21/19** - The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "UM15.008: Under/Over-Utilization which has been amended in collaboration with similar organizations, local and regional health plans to compare and create benchmarks of utilization goals. **11/06/19** - The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - An email (11/06/19) which includes a description of the MCP's process for working with similar entities on establishing benchmarks and to put into place best practices. The MCP is utilizing the healthcare cost and utilization project comparison tool to monitor best practices on both a state and national Level - Healthcare Cost Utilization Project Comparison - Tool for inpatient utilization.

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				- Sample Report, State Trends in Inpatient Stays by Payer" and "Trends in Inpatient Stays" is a monitoring tool for detecting the over and under-utilization of services and areas for cost control and improvement that can be viewed on both the State and National Level. **1/10/19-** The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - Updated P & P, Policy # UM15.008, Under/Over-Utilization has been amended to include an additional section regarding the plans data on various levels to focus on performing entities. The MCP can then evaluate areas of attention for improvement and analysis. The MCP will also be utilizing NCQA Quality Compass to use as baseline tool for facility services including: ER, Outpatient, Inpatient and overall

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				quality of care. (page 2) **This finding is closed**
1.1.3 Revise and implement policies and procedures to ensure that all UM staff who are involved in clinical decision-making participate in the Plan's chosen method (e.g. IRR studies) to maintain consistency in the application of criteria. Furthermore, policies and procedures should include a scoring system and a defined threshold for passing or failing.	1.1.3 The Utilization Management Dept. reviewed and revised UM Policies and Procedures. All UM staff that are involved in the clinical decision -making process have reviewed the updated/revised UM Policies and Procedures. UM Staff annually signs verification of Policy review 1. The Registered Nurses scoring system will be consistent with the Physician scoring system with a defined threshold for passing of 90%. IRR will be conducted quarterly. 2. The UM Dept is in a trial period using the InterQual IRR Data service to produce	1.1.3 UM Policy 15.006-Tracking Utilization Systems	**October 16, 2019** **January 2020 for mock audits**	**11/06/19** – The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "UM 15.006: Tracking Utilization Management Systems" (10/16/19) which has been amended to include the process of IRR testing for nurses. The process includes the testing being done quarterly and scoring system with a targeted threshold for passing of 90% (page 3-4). The P&P also includes an Attachment A of the IRR Audit Tool for reviewing denied TARs and upheld Appeal PARs. - BIM/CFS meeting minutes (11/04/19) which provide evidence of documented

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	optimal IRR Reports and maintain compliance with DHCS, DMHC and NCQA. 3. The UM Dept.. has adopted an Internal Audit Team to conduct Mock Audits based on the DHCS Technical Assistance Guide to maintain compliance with regulatory bodies. 4. All UM nurses will participate in the IRR process			review and discussion that all nurses are to review revisions to the UM Policy UM 15.006 and sign acknowledgement of review. - UM Nurses Acknowledgement of Review signatures as evidence that UM nurses have reviewed the revised P&P UM 15.006 and are aware of the process of the IRR testing. **02/06/20** – The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - Draft Quality Council (QC) meeting minutes (01/23/20) which provide evidence that IRR testing was done for the second half of 2019 and the IRR for the examined period was reported to be within guidelines (each nurse scored 100% for the 15 cases). The QC minutes will be finalized in February (page 2).

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				This finding is closed.
1.1.4 Implement policies and procedures to continuously monitor and evaluate all UM delegated functions.	1.1.4 The UM Dept has amended UM15.007 to specifically specify the Behavioral Health Audit Schedule and identify what has been delegated. These Policies and Procedures ensure that delegated UM activity are continuously monitored and evaluated. The UM delegated functions of the following delegates are addressed in the policy: 1. Behavioral Health and 2. CCRMC 3. Delegates are required to report to the UM Dept. on the annual dates following: a. 2/28 b. 5/31 c. 8/31 d. 11/30 The policy will be	1.1.4 UM15.007 (Utilization Management Delegation)	**January 2020**	**10/22/19** – The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "UM15.007: Utilization Management Delegation" (10/15/19) which has been amended to include a section on delegation of UM activities of Behavioral Health. The section includes the Behavioral Health Audit schedule in which delegates are required to report to the UM department on a quarterly basis on the following dates: 2/28, 5/31, 8/31, and 11/30. The Medical Director is required to review quarterly reports within 30 days and report findings to the Quality Committee. To ensure that MCP is continuously monitoring, MCP has

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	revised to include this detail 4. Medical Director (or designee) will review within 30 days of receipt of the report and will determine if it is appropriate. When final report is accepted, the Medical Director will report any findings to the QC. 5. UM Dept has implemented a new annual audit schedule with (Full Audit Tool) conducted as follows: a. On-site Audits conducted on odd years e.g., 2019 b. Desk Audits are conducted on even years 2020 etc.			implemented a new annual audit schedule with the Full Audit Tool. On-site audits are conducted on odd years and desk audits are conducted on even years (page 2). **11/15/19** – The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - Audit tool, "CCHP UM Auth and Denial Fil1.2.2e Audit Tool for Contra Costa County Behavioral Health" and "Utilization Management" as evidence that MCP is conducting a complete review of all delegated functions. **03/03/20** - *CCHP 2019 Delegated BH UM Auth Denial-Appeal and File Audit Report* as evidence (30 Randomly selected Authorizations including denials) **3/3/20** – Signed –Approved 2019 UM BH *Delegation Oversight Audit a*s evidence of 12/11 – 12/12 audit

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				results for CC County Behavioral Health Program (Signed on 2/18/20 more than 30 days beyond audit which will need to addressed with MCP). **This finding is closed.**
1.1.5 Develop and implement policies and procedures to ensure receipt of delegated UM activity reports at least quarterly and adherence to delegate contract reporting requirements.	1.1.5 See 1.1.4. UM15.007 has been amended to include specific quarterly reporting dates.	1.1.5 UM15.007 Utilization Management Delegation	**January 2020**	**10/22/19** – The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "UM15.007: Utilization Management Delegation" (10/15/19) which has been amended to include a section on delegation of UM activities of Behavioral Health. The section includes specific reporting dates of 2/28, 5/31, 8/31, and 11/30 to ensure that MCP is conducting continuous monitoring and oversight of all delegated activities. **11/04/19** – The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - An email (11/04/19) which

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				includes a description of the items specified in the UM report: IRR, Turn Around Time, Over and Under Utilization, appeals/denials/referrals, and UM Committee Minutes with references to quarterly delegate reporting. **3/3/20-** Quality Council Meeting Minutes (January 23, 2020) presenting UM Quarterly Report. **3/9/20 –** ***BH Auth Turnaround Time Statistics and Analysis Q42019 and 2020*** *report* submitted as evidence of receipt of delegated UM activity reports at least quarterly. **This finding is closed.**
1.1.6 Revise delegation agreements to ensure the Plan's oversight, monitoring, and evaluation processes are in writing.	1.1.6 The Mental Health MOU already contains remedies available to CCHP in the event the delegate does not perform delegated activities. See MOU 1st Amendment. CCHP will, however amend the MOU to include the audit schedule process. This information will	1.1.6 Attachment (Mental Health MOU) UM Policy and Procedure UM 15.007 (UM Delegation)	**January 2020**	**10/21/19** – The following documentation supports the MCP's efforts to correct this finding: -Updated P&P, "UM15.007: Utilization Management Delegation" (10/15/19) which has been amended to include a section on delegation of UM activities of Behavioral Health. The section

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	also be amended to UM15.007.			includes specific reporting dates of 2/28, 5/31, 8/31, and 11/30 to ensure that MCP is conducting continuous monitoring and oversight of all delegated activities. MCP's Medical Director must review quarterly reports within 30 days and approve, deny or request additional information. Annual audit schedule includes onsite audits in odd years and desk audits in even years. -Behavioral Health MOU which has been amended to include oversight measures that the delegate must provide the MCP a quarterly UM Summary Report on the specific reporting dates of 2/28, 5/31, 8/31, and 11/30. The MOU has also been amended to include that deficiencies will have a corrective action plan and if delegate does not comply with corrective action plan, the MCP may revoke delegation (page 1). **This finding is closed.**

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1.2.1 Develop and implement policies and procedures to ensure that UM staff carefully reviews and uses the appropriate criteria to make medical necessity decisions to avoid inappropriately denying services.	1.2.1 In order to avoid inappropriately denying medically necessary services/ & improve UM medically necessity reviews, the Medical Director will review Appeals Over-turns and IRR Discrepancies at his UM Consultants Meeting that he leads bi-monthly. UM staff have also been retrained on UM Policies and have acknowledged that they have reviewed updated policies.	1.2.1 UM Committee Meeting Signatures/Sign-In Sheet and Agenda UM Policy and Procedures (UM15.003)	**11/13/19**	**10/21/19** – The following documentation supports the MCP's efforts to correct this finding: - In the "Action Taken" column of the CAP, the MCP states that the Medical Director will review Appeal over-turns and IRR discrepancies at the UM Consultants meeting that is held bi-monthly. - P&P, "UM 15.003: Policy for Prior Authorization" that outlines the MCP's process for prior authorization requests. Process includes UM staff appropriately reviewing written clinical criteria or guidelines to ensure consistent review and decision-making of prior auth requests. **11/13/19** – The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - Medical Consultants Work Group meeting minutes (Jan,

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				Mar, May, Aug 2019) which provide evidence of discussion that Medical Consultants are reviewing criteria and consistent application of criteria. Minutes also show documented review of "all physicians scored 100% in IRRT results" from the recent quarter. - Utilization Review Committee Meeting agenda and sign-in sheets (08/21/19) as evidence that UM staff have been retrained and reviewed UM's updated policies. **This finding is closed.**
1.2.2 Develop and implement policies and procedures to ensure that all UM staff uses updated criteria to make medical authorization decisions. Criteria should be based on	1.2.2 The UM Dept. has purchased Apollo Criteria and Guidelines for Outpatient utilization of medical necessity decisions and received the InterQual criteria navigation demo guidelines for Inpatient medical necessity decisions. Currently utilizing the InterQual trial period. The UM Dept. is	(Purchase Agreement UM Policy and Procedures (UM15.003)	**4/18/19**	**10/21/19** – The following documentation supports the MCP's efforts to correct this finding: - Software and Service Agreement (Term 4/18/19-4/17/20) between Contra Costa Health Plan and Apollo Managed Care to ensure that MCP is using updated criteria

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sound medical evidence, consistently applied, regularly reviewed, and updated.	purchasing the InterQual Criteria upon completion of InterQual Trial Period.			and guidelines for outpatient utilization of medical necessity decision. (Page 1- 1(c) Guidelines and Schedule A-Products) **11/19/19** – The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - An email (11/19/19) which includes a description of MCP's process when criteria/guidelines are periodically reviewed and updated, "at each UM Committee Meeting, standing agenda item will confirm current version of InterQual and Apollo criteria." If there is a change in criteria, "training must be conducted on the changes." - P&P, "UM15.006: "as evidence that the MCP has a process when there is inconsistent application of criteria/guidelines. Corrective

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				action plans could include, but not limited to educational activities, supervision of decisions, increased oversight of UM decisions, or prohibiting the physician from making UM decisions. **01/03/20** – The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - Utilization Management Meeting agenda (12/18/19) as evidence that the UM Committee discussed InterQual and Apollo criteria. - Updated P&P, "UM 15.002: Utilization Review Criteria and Guidelines" which has been amended to include that the "physician is the ultimate decision maker will verify that the nurse who chooses the criteria has made the correct choice" (page 3). **03/03/20 -** The following additional

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				documentation submitted supports the MCP's subsequent efforts to correct this finding: -File Reviews – #2378881, #2395834, #2402072, #2418746, #2426541 as proof of internal audits. **03-16-20** - The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - An email stating that MCP is still in negotiations with InterQual but is still utilizing Apollo which has updated criteria and guidelines. **This finding is closed.**
1.2.3 Develop and implement policies and procedures to ensure that all UM staff document their reasons for decisions for all medical	1.2.3 The UM Dept. has reviewed and revised all UM polices and re-trained UM Staff. Specifically, UM15.015 will be amended to include that all M.D./Physicians will sign and make an indication of medical record.	UM 15.015	**10/24/19**	**10/21/19** – The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "UM15.015.a: Timeliness of the Utilization Review Decision and Communication" (10/15/19)

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authorizations.				which has been amended to include that Medical Directors/physicians will sign and make indication of medical record. **11/14/19** – The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - UM Department staff training sign in sheets and UM P&P sign in sheet as evidence that UM staff have acknowledged the revised P&P. - Seven sample concurrent cases as evidence that physicians are documenting their findings and reasons for decisions. In each case, physicians document in their medical notes that they have reviewed the case with the RN and their reason for utilization management decision. **This finding is closed.**

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1.2.4 Develop and implement policies and procedures to ensure that all NOA letters are clear, concise, and at a sixth grade reading level.	1.2.4 The UM Dept. is developing and implementing procedures in coordination with CCHP's C&L Manager to ensure all NOA letters are clear and concise at the 6th grade reading level. The UM Dept. has sampled the top 5-10 Top Reasons used for Denials and this language will be sent to C& L (Cultural & Linguistics Manager) for language simplification.	Selection of NOA letters revised to 6th grade reading level.	**January 2020**	**10/21/19-**The following documentation supports the MCP's efforts to correct this finding: - Sample NOA Letters that have been reduced to a sixth grade reading level serves as evidence of the MCP's focus on the NOA process to keep letters clear, concise and at a sixth grade reading level. **11/22/19**- The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - UM staff training "Shorten Your Message" and sign in sheets as evidence of updated NOA letter training. The training gives important information about compound-complex sentence structure and shorter messages for clear and concise notifications for readers. **11/24/19**- The following additional documentation submitted supports the MCP's subsequent efforts to

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				correct this finding: - Updated P&P, Policy Title "Member Readability Process for Utilization Management Notice of Action" (01/01/20) which been developed to ensure all Notice of Action (NOA) letters are written and tested to ensure all letters are at a 6th grade reading level. It requires, all UM Staff will receive training on language readability and shall coordinate with Health Educator and C&L Manager to ensure readability. The UM team will be conducting annual in-house audits to ensure the letters meet readability standards. - Sample NOA Letter, with track changes showing the plans changes to modify the letter with respect to readability requirements. **11/27/19**- The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - Training Sign-in Sheet (8/12/19) is evidence of the training to re-

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				establish UM timelines, included retrospective review timeframes with new and existing staff. **This finding is closed**
1.2.5 Develop and implement policies and procedures to ensure that a medical necessity review of retrospective requests is performed.	1.2.5 CCHP underwent extraordinary circumstances affecting our UM Dept staffing. To address this, CCHP has improved staffing ratios. CCHP already has policies in place to ensure retro auth reviews. We have re-enforced our UM Staff training by emphasizing UM15.015a in recent training in September 2019 to ensure medical necessity retro respective requests are performed per our existing policy.	Training Sign-in Sheets	**8/12/19, 8/14/19, 8/27-29/19**	**10/21/19** - The following documentation supports the MCP's efforts to correct this finding: - Updated P & P, Policy # UM15.015 (10/29/19) has been amended to ensure medical necessity denials are made by the Medical Director or designee. The Medical Director will sign and make an indication in the member's medical record. - Training Sign-in Sheet (8/12/19) is evidence of the training to re-establish UM timelines, included retrospective review timeframes with new and existing staff. - An email (10/29/19) and revised P&P UM15.015a which includes a description of the Internal audit process which is being accompanied by the MCP's

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				monitoring of the UM Department timeliness by the guidance of the DHCS TAG for Medical Audits. The UM staff will be comprised of an M.D. and a R.N., that will work with the MCP's Compliance Unit to review all Category 1 – UM Requirements on an annual basis. - MCQMD provided technical assistance to insure MCP included DHCS approved "Your Rights" attachment with revised P&P. **This finding is closed.**
1.2.6 Develop and implement policies and procedures to ensure that correct timeframes for processing all medical authorizations are followed by UM staff. Develop and implement policies and procedures to	1.2.6 CCHP has conducted trainings to review and follow UM Policies to ensure correct timeframes are adhered to for processing all authorizations, including the process to send delay letters in a timely manner. Training will be for all UM Staff including RNs and HPARs. CCHP will also implement annual training to review any revised policy.	Training Sign-in Sheets	**5/21-28/19, 6/12/19, 6/14/19, 6/17/19, 6/20/19**	**10/21/19** - The following documentation supports the MCP's efforts to correct this finding: - Training sign-in sheet from UM Policy training serves as evidence UM staff has been trained on ensuring the correct timeframes for processing authorizations including the sending of delay letters. **1/21/21** - The following

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ensure that delay letters are sent to the providers and members in cases where the timeframe is extended an additional 14 calendar days.	Issues regarding staffing ratios have improved.			documentation supports the MCP's efforts to correct this finding: - Policy UM15.003 contains the correct time frames for Medical Authorizations. **5/14/21** - The following documentation supports the MCP's efforts to correct this finding: - Screenshot from cclink system shows that fields were added to trigger turnaround time calculation. - 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. **This finding is closed.**

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1.2.7 Develop and implement policies and procedures to ensure that NOA "Your Rights" information sent to members is correct and updated.	1.2.7 The NOA "Your Rights" information in the policy and procedures sent to members has been revised and corrected.	"sample denial letter" with rights attachment.	**June 2019**	**10/21/19**- The following documentation supports the MCP's efforts to correct this finding: - Sample denial letter with "Your Rights Attachment" serves as evidence that the MCP is now using the "Your Rights Attachment with the correct updated information. **This finding is closed.**
1.3.1 Revise and implement policies and procedures to ensure that written consent is obtained when a provider files an appeal on the member's behalf.	1.3.1 Effective immediately following the audit, all pharmacy provider appeals submitted on behalf of the member (i.e., All pharmacy appeals were no longer processed through the health plan's member services dept.(fall under the purview of member services policy MS 8.018- Appeal Process for Medi-Cal Members), which requires that a member's written consent is obtained for all provider appeals submitted on behalf of the member.	1.3.1 See Member Services Policy MS 8.018 (Appeals Process)	April 2019	**10/22/19** - The following documentation supports the MCP's efforts to correct this finding: - CAP Narrative signed by Pharmacy Director states that all pharmacy appeals are processed through the MCP's member services department falling under the purview of policy MS 8.018 – Appeal Process for Med-Cal Members, which requires member's written consent to obtained for provider appeals submitted on a member's behalf. All pharmacy provider appeals since April 2019

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				- Policy MS 8.018 which pharmacy appeals now fall under requires written consent from member for appeals submitted by a provider on a member's behalf. - Member consent form submitted by the MCP used to obtain member consent for provider initiated appeals. **This finding is closed.**
1.3.2 Develop and implement policies and procedures to ensure that correct timeframes to file an appeal are reflected in provider informing materials including the provider manual.	Attached PA9.816. Section highlighted that describes Provider Manual Update process.	Attachment 1.3.2 (See PA9.816)	May 2019 **(Existing Policy Revised 10.2019)**	**10/21/20** - The following documentation supports the MCP's efforts to correct this finding: - Revised policy PA9.816 was updated to describe the updating process for the provider manual. The manual is updated as changes occur throughout the year and reviewed in its entirety on an annual basis in the fall. - The Provider Manual located on the MCP's website has been updated to include the correct State Fair Hearing timeframe.

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				This finding is closed
1.4.1 Revise and implement policies and procedures to ensure that referral and prior authorization are not required for members to obtain an initial mental health assessment. Develop and implement processes to ensure that members' and providers' informing materials clearly state that a referral and prior authorization are not required.	Revised Provider Manual to reflect that no authorization is required for mild to moderate mental health services.	1.4.1 Excerpt from Provider Manual.	**May 2019**	**10/21/20** - The following documentation supports the MCP's efforts to correct this finding: - Excerpt from Provider Manual was updated to state that mild to moderate mental health services can either self-refer or be referred by their PCP. **7/17/20** - The following additional documentation supports the MCP's efforts to correct this finding: - Care Management Unit 2019 Program Description and Manual have been updated to not require prior-authorization for initial assessments. **This finding is closed.**

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2. Case Management and Coordination of Care				
2.1.1 Develop and implement procedures to ensure the provision of an IHA to new members within 120 calendar days from enrollment.	We had our largest network revise their preventive services policy to list all elements of an IHA and to correct deadline of 120 days. The Medical Director added the topic of the requirement to perform an IHA within 120 days to his quarterly provider meetings. An article was also published in the provider newsletter. We have reminded practices that we send them listings of new members assigned to them and reinforced the expectation that they will reach out to schedule an IHA. We are partnering with Public Health and the school systems to target seeing children in the schools and help ensure provision of all preventive services due. We have adopted a new process to give providers lists of their new patients who have not yet had visits and ask	Policy QM14.701, as highlighted	Policy and education complete as of 10/15/19. Partnering with Public Health and schools, Q1 2020.	**10/21/19**-The following documentation supports the MCP's efforts to correct this finding: - Updated P & P, "Policy Number QM14.701 Preventative Services/ Initial Health Assessment has been amended to include a section on Initial Health Assessments and the importance of having age appropriate documentation, including the Individual Health Education Behavior Assessment/Staying Health Assessment (SHA). In addition, to providing a detailed history of the patients past medical records. (Page 2) The P & P also includes the need for an annual compliance study to verify the current methods are satisfactory to IHA completions. (Page 5) **10/29/19**-The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding:

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	them to reach out to schedule.			- The Community Provider Network Newsletter, serves as evidences that the MCP is effectively outlining the Initial Health Assessment (IHA) and importance of the 120 day requirements for new patients that will include an IHEBA, such as the SHA. (Page 17) Also documentation is stressed to ensure missed appointments are rescheduled and negative results could impact the MCPs CAP. **01/06/20**-The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - Quarterly Community Provider Network (CPN) Meeting Minutes (07/19) which occurred at multiple locations and accompanied by sign-in sheets serves as evidence of the MCPs focus on IHAs, supported by SHA and USPSTF along with new member requirements.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				- PowerPoint Training, "IHA Tracking and Oversight " (12/20/19), sign-in sheets, and "Member Outreach Strategy Handouts are evidence that MCP staff received training related to IHA's and the importance of tracking purposes to ensure the 120 day requirements. - Updated Operational Policy, "Initial Health Assessment (IHA) Oversight & Management (01/01/20) provides evidence of the MCP's training efforts including continued Responsibility and understanding of completing IHA for Medi-Cal Members. **This finding is closed**
2.1.2 Implement policies and procedures to ensure provision and documentation of all components of an IHA, including	IHA policy was revised to clarify what elements an IHA must contain and to emphasize the need to deliver all appropriate preventive care. Reminders and specifically lung cancer screening recommendation	Policy QM14.701, highlight p.5.	Complete as of 10/15/19.	**10/21/19**-The following documentation supports the MCP's efforts to correct this finding: - Updated P & P, Policy Number: QM14.701, Preventative Services/Initial Health

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
applicable preventative services.	were topics in the Medical Director's quarterly meetings with providers.			Assessment", which requires MCP to document all components of an IHA and follow the latest edition of the Guide to Clinical Services published by the USPSTF, specifically the A and B recommended preventative services. Monitoring for completion of IHAs is conducted through quarterly iSite reports and facility site reviews. Monitoring results are reported to the Clinical Leadership Group and reviewed for potential corrective action. MCP promotes completion of IHAs through provider orientation, twice monthly provider notifications, pediatric and adult prevention guidelines and annual compliance studies to determine whether methods used to measure compliance are reliable. **11/21/19**-The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding:

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				- Multi-Location Meeting Minutes (1/2019, 4/2019 and 7/2019) which provide evidence of documented review and discussion of IHA updates, including timelines for completion, new members, and the importance of lung cancer screenings. **03/13/20**-The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - Sample Report "IHA Monitoring" is evidence that the MCP performed an annual audit/compliance study on the MCP's existing system iSite which is responsible for tracking the compliance of members and ensuring they are properly receiving IHA's. The audit revealed that a large amount of those that were pulled up on the report were in fact not new members and therefore did not need an IHA which caused incorrect data. The report has since been revised to ensure this computer malfunction will

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				not affect IHA data negatively. **06/02/20** - The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - Sample Audit Report, "IHA Study (03/2020), MCP IHA Report (2018-2019), and IHA Verification Study (May 2020) serves as evidence that the MCP is conducting a detailed compliance study with emphasis on preventative services not included in health maintenance. The MCP focused on multiple issues including:" verification of revised report used to measure compliance, outreach and the concern that preventative services without automatic reminders may be missed." The MCP will continue quarterly monitoring of compliance and in regards to oversight will be presenting the material to the Clinical Oversight group. The MCP will be conducting an annual study to confirm the date is indeed reliable, similar to what was presented in the May data.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				This finding is closed
2.1.3 Develop and implement policies and procedures to completely and accurately assess each newly enrolled SPD member's current health risk in accordance to *APL 17-013*.	Incorrect policy submitted during audit. CM is revising policy and assessment form to include LTSS questions. Submit to DHCS for approval	Policy CM 16.019	11/2019	**05/18/20** - The following additional documentation supports the MCP's efforts to correct this finding: - Updated P&P, "CM16.019: SPD Risk Stratification and Health Risk Assessment and HIF/MET Process" (March 2020) which has been amended to include Long-Term Services and Supports (LTSS) Referral Questions to the SPD Health Assessment Tool. The SPD Health Assessment Tool now includes all the required elements of an HRA such as assessment of functional limitations on activities of daily living, housing, and health literacy (pages 7 – 10). - Submission Review Form, "P&P CM 16.019 SPD Health Risk Assessment and HIF/MET Process" (03/20/20) as evidence that the MCP submitted this P&P for review to DHCS. The P&P was reviewed and approved by the

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				DHCS MCQMD Nurse Evaluator on March 20, 2020. **This finding is closed.**
2.1.4 Implement policies and procedures to initiate and develop individualized care plans for members identified through the HRA process as high-risk. Develop and implement a process to monitor the initiation of Individual Care Plans.	Incorrect policy submitted during audit. CM is revising policy to include how individual care plans are initiated, implemented & monitored for high risk members.	Policy CM 16.019	11/2019	**10/21/19** - The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "CM16.019: SPD Risk Stratification and Health Risk Assessment and HIF/MET Process" (September 2019) which has been amended to include that the Case Management Manager or RN designee will provide oversight of the Care Plan and the implementation of interventions. The Member Service Counselor will enter the data into Epic and forward the case to the RN for review of the Care Plan (page 3). **This finding is closed.**
2.4.1 Develop and implement policies and procedures to establish the use of	2.4.1. CCHP has already developed a minor consent form and obtained DHCS approval on 5/29/19.	CCHP Consent form and Approval.	5/29/19	**10/21/19** – The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "16.028.1, Non

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
written consent forms to meet contractual requirements for NMT and NEMT services for unaccompanied minors.				Emergency Medical Transportation(NEMT)" which has been amended to include a section on addressing unaccompanied minor consent forms. The policy states that, CCHP is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor (page 2 – 3). The MCP has revised P&P to address minor consent forms for transportation and developed a DHCS approved (MCOD) unaccompanied minor consent form. - Transportation Unaccompanied Minor Consent Form (05/29/19) as evidence that the MCP is requiring written consent forms in the provision of NEMT and NMT services for unaccompanied minors. The MCP received DHCS approval for this form on May 29, 2019. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
2.4.2 Implement policies and procedures to establish the use of DHCS approved PCS forms for NEMT	2.4.2 UM Dept has UM16.028.1 for use of the DHCS PCS (Physician Certification Statement) Form. This form was approved on July 18, 2017. UM will ensure that this policy is implemented and utilized for all NEMT.	2.4.2 NEMT Approval form	July 2019	**10/21/19** – The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "16.028.1, Non-Emergency Medical Transportation (NEMT)" which includes that CCHP must use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members (page 3). - Physician Certification Statement (PCS) for NEMT Form (07/18/17) as evidence that the PCS form includes categories such as the Function Limitations Justification, Dates of Services Needed, Mode of Transportation Needed, and Certification Statement. **03/12/20** – The following additional documentation supports the MCP's efforts to correct this finding: - Samples of completed Physician Certification Statement (PCS) forms which include the categories of Function Limitations Justification, Dates of Services Needed, Mode of

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				Transportation Needed, and Certification Statement. The MCP has confirmed that these sample PCS forms includes those categories. **This finding is closed.**
3. Access and Availability of Care				
3.1.1 Develop and implement policies and procedures to ensure initial prenatal appointments are monitored for timely access.	3.1.1 A study has been done to confirm compliance with the standard for timely initial prenatal appointments. That study is being submitted for the CAP. We will also add to the access policy that these studies will be performed twice a year.	Initial Prenatal Appointment Access—RMC Policy QM14.101	Study complete and reported to Clinical Leadership Group. Policy updated 10/14/19.	**10/21/19** – The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "Policy Number: QM14.101, Access to Care Standards" (04/25/19) which has been amended to include that the Quality Department will do a study twice a year to confirm compliance with the standard for timely prenatal appointments (page 4). - A study performed by the plan, "Initial Prenatal Appointment Availability" (June 2019) as evidence that the plan is monitoring prenatal appointment availability. The study tracks if the appointment requested date and appointment availability

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				time is compliant. **10/29/19** - The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - Updated P&P, "Policy Number: QM14.101, Access to Care Standards" which has been amended to include that if the percentage compliance is below 85%, the MCP will follow up with the non-compliant CPN providers and make sure they understand this requirement. In RMC network, the MCP will follow up with Appointment Line and Ambulatory Care Director to ensure the requirement is understood and to troubleshoot any barriers (page 4). **This finding is closed.**
3.1.2 Implement policies and procedures to ensure updates are made to the provider directory to reflect accurate information.	3.1.2. We have re-attached, PA9.802, PA9.825, and PA9.829 that address updates to the provider directory. We have identified the majority of the audit sample were CCRMC providers, and	3.1.2 PA9.802 PA9.825 PA9.829	10/15/19 Audit, anticipated CAP by end of 2019.	**10/21/19** – The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "Maintenance of Provider Network Data and review of Network Provider Availability"

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	we will be auditing CCRMC on 10/15/19 and expecting to implement a CAP on them to assure that they develop processes to provide accurate information to CCHP for our Provider Directory.			(01/10/19) which ensures complete and accurate provider network data by performing quarterly reviews of its contracted provider database. Reviews will be conducted once per quarter each year to allow for any changes to be made to provider directories, Provider Maintenance Information System (PMIS), internal listings and On-Line Search Engine (OSE). Verification of information will be tracked electronically using the on-line interface and for those providers unable to process electronically on the Provider Network Update (PNU) form and will include information CCHP lists in its directories regarding the provider or provider group. - Form, "Provider Network Update" which allows the MCP to verify the provider contact information that they have on file for the provider on a quarterly basis. - Updated P&P, "Web Based Directory" which discusses the procedures for updates to the online

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				provider directory. The MCP will send a data feed from PMIS to OSE nightly and any changes in data is updated and displayed on OSE. Data in PMIS displayed on OSE is obtained from credentialing information submitted by the provider at the time of initial credentialing and recredentialing. The information is primary source verified by the MCP's contracted Credentialing Verification Organization (CVO) Verifpoint, and then entered into PMIS. Information in PMIS is updated as changes occur and within thirty (30) business days after the MCP has been notified by a provider, member or public that information listed is incorrect. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
3.3.1 Implement policies and procedures to process non-contracted family planning and emergency service claims at the appropriate Medi-Cal FFS rate. Including configuration of claims system and monitoring to ensure reimbursement rates are updated and accurate.	3.3.1 1. Track new out of network providers for Family Planning services and Emergency Services and have the IT Team and Claims Staff audit the claims quarterly to ensure the current Medi-Cal fee schedule is used. 2. Business Rules Review for Claims Adjudication for out of network (Quarterly Review starting Q-4 2019). 3. Quarterly Tap Reports on Family Planning and Emergency Services CPT Codes (starting Q-4 2019) for audit by Claims Management Team. 4. The entire Claims Examiners Team was trained on the procedures on how to pay Family Planning and ED non-contracted claims in early 2019, however they will be retrained again in 2020.	2018 Claims meeting and training documentation.	4th Quarter 2019	**10/21/20** - The following documentation supports the MCP's efforts to correct this finding: - PowerPoint training, "Claim Examiners Training" (01/30/2019) and sign-in sheets as evidence that the MCP's Claims Unit staff received training. The training materials address that any emergency room claim, and any family planning, sensitive service, abortion, HIV claim is payable for any Medi-Cal member, at any Medi-Cal provider regardless of network with no authorization required. **04/23/20** - The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - Spreadsheet Audit Reports, "CCHP DHCS ER & SSS Reports (TAP4363) Emergency Room Claims" and "CCHP DHCS ER & SSS Reports (TAP4363) Family Planning Claims" (01/01/20 – 03/31/20) as evidence that the MCP is tracking new out of network providers for Family

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				Planning services and Emergency Services. The IT Team and Claims Staff audit the claims quarterly to ensure the current Medi-Cal fee schedule is used. The Auditor Claim Details tab includes an Audit Status column and notes if the audited claim was paid correctly. - PowerPoint training, "Claims Operations Training" (April 2020) and sign-in sheets as evidence the MCP's Claims Unit staff received training. The training materials address that the MCP pays non-contracted family planning providers with no less than the Medi-Cal FFS rate. It also addresses the Quarterly Claim Audit which ensures that current Medi-Cal Fee Schedule is used and to ensure that CPT code are accurate configured in ccLink. The MCP performs a quarterly audit to ensure all emergency services are paid at the correct level. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
4. Member Rights				
4.1.1 Revise and implement policies and procedures to ensure that quality of care grievances are appropriately investigated and adjudicated. Implement policy and procedures to ensure categorization of quality of care grievances as PQIs when a potential quality issue is identified.	4.1.1 Policies on grievances, PQIs, and Provider Corrective Action were all revised to ensure grievances are all appropriately investigated and that meaningful follow up actions are taken. We are creating a new unit to support the grievance function and ensure all are appropriately processed.	Policies QM14.502; QM14.503, and MS8.001	Policies will be approved 10/24/19.	To address this finding the MCP assigned all incoming grievances to the clinical staff to ensure appropriate categorization of quality of care grievances. **10/21/19** – The following documentation supports the MCP's efforts to correct this deficiency: - Updated P&P, "MS8.001: Handling of Complaints and Grievances" which has been amended to include a section on monitoring of all incoming grievances by clinical staff to ensure appropriate categorization of quality of care grievances. (Section 1, H (1) & (2)). Furthermore, the Medical Director will determine any needed follow up actions as described in policy "QM14.503: Provider Corrected Action." **02/24/20** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: - Sample Grievance Report

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				(01/23/20) "CCHP Quality of Care Grievance Report to Quality Council" includes summary of closed grievances related to quality of care. The assessment period is 01/01/2010 through 12/31/2019. The report addresses various components including: • Timely resolution of grievances (Resolved within 30 days) • Grievances by Provider • Grievances by Facility/Location • Outcome by Severity • Outcome: Evaluation of Care • Provider Preventable Conditions - The MCP's written response (02/24/20) confirmed the MCP's Quality Director is now presenting these results at Quality Council to monitor the grievance system for tracking and trending of any patterns. - Quality Council Meeting Minutes (01/23/20) includes review of Quality of Care Grievance semi-annual report and Provider Preventable Conditions. This evidence the MCP has a system for reporting

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				procedures to improve plan policies and procedures.(Title 28, CCR, Section 1300.68(b)(1) **05/28/20** - Revised P&P (05/28/20), "MS8.001: Handling of Complaints and Grievances" clarifies the requirement for written notification to regarding the status of the grievance and the estimated date of resolution. No extension on Grievance resolution timeframes. The grievances shall be resolved in 30 days. (Section H.5) **This finding is closed.**
4.1.2 Implement policies and procedures to ensure grievances are appropriately classified, processed and resolved.	4.1.2 All grievances including exempt grievances will be reviewed by the Grievance Nurse. The Grievance Policy and Procedure has been modified to ensure grievances are appropriately classified, processed and resolved. Additionally, the Health Plan is working with IT Department to implement a system that closed Exempt Grievance CRMs are automated sent to the	MS 8.001 Policy	MS 8.001Policy will be approved 10/24/19	**10/21/19** – The following documentation supports the MCP's efforts to correct this deficiency: - A draft P&P (10/15/19), "MS8.001: Handling of Complaints and Grievances" was updated to ensure consistent classification and processing of exempt grievances. "All incoming grievances *including exempt* grievances will be reviewed by the Grievance Nurse to ensure that any potential quality of medical

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	Grievance Nurse to be reviewed.			care issues or clinical issues are handled by clinical staff." (Section III, E) Exempt grievance data will be reported on a quarterly basis in order to trend and identify opportunities to improve the delivery of care and the accessibility of service. (Section III, G) The Medical Director will determinate any needed follow up actions as described in policy "QM14.503: Provider Corrected Action" <u>Monitoring</u> "Grievance data will be reported on a quarterly basis. Reports are compiled so that trends can be identified to detect opportunities to improve the delivery of care and the accessibility of service. Grievance reports are submitted semiannual, to the Plan's quality assurance committee (Quality Council) for review and appropriate action, and quarterly to the Managed Care Commission and to the Plan's Governing Body (Joint Conference

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				Committee of the Board of Supervisors). This information is used to analyze how the Health Plan's existing programs or services need to be modified and/or improved to better serve members and/or to determine what new services may need to be added."(P&P MS8.001, Section R.) **02/24/20** – The MCP submitted additional documentation: - A sample Grievance Report "CCHP Quality of Care Grievance Report to Quality Council 1/23/2020. Cases Closed January 1, 2010-December 31, 2019" used to monitor the grievance system. The MCP confirms reporting of this data to Quality Council for tracking and trending of any patterns. (MCP's written communication 02/24/20) - "Quality Council Meeting Minutes 01/23/20" as evidence of established oversight procedures. "The Quality Director presented the semi-annual report of quality of care grievances and also Provider Preventable

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				Conditions (PPCs). He reviewed the various tracking categories, comparing 2019 to prior years. There were no notable trends or concerns. Severity continues to be low and most required no follow up." **This findings is closed.**
4.1.3 Develop and implement policies and procedures to capture all grievances.	4.1.3 Provider Relations Power Point Training Material has been updated to address grievances (PCP, Specialists, CCHP Behavioral). Grievances and appeals are covered in the Policy PA9.816 Provider Training. Provider Manual Section 12 Member Services Complaints and Grievances. Article to Provider Bulletin. Quarterly Community Provider Network (CPN) Meeting has a section about the Grievance Process.	Excerpt from Provider Manual Section 12-Member Services, Policy PA 9.816, PCP, Specialists and CCRMC Orientation Power Points	October 2019	To address the issue of grievances being processed internally by providers, but not forwarded to the Plan the MCP took the following step: **10/21/19** – The following documentation supports the MCP's efforts to correct this deficiency as stated in Action taken column: - Updated PowerPoint training "CPN-PCP Orientation 2019", "CPN Specialist Orientation 2019" and "RMC Orientation 2019" address requirements of capturing all grievances and forwarding them to the MCP. (Slide 15) - Excerpt from the Provider Manual Member Services (Section12) supports the MCP's effort to reiterate

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				Provider requirement to assist the member with the grievance form and immediately direct it to the Plan's Member Services Department. Instructions on how to file the form are included. - A draft P&P (October 2019), "PA9.816: Provider Training" was updated to ensure newly contracted Providers are given CCHP's Provider manual which includes Grievance and Appeal Procedures. The P&P commits Provider Relation staff to conduct ongoing provider manual training to the provider network as it is updated with new materials. The link to the electronic Provider Manual is included in the Quarterly Provider Bulletin. After the orientation, the providers are required to sign an attestation form they have received training on the provider manual. Additionally, in order to ensure all providers, existing and new, are aware of a process and receive the same information, it is provided through the MCP's Quarterly provider bulletin. The bulletin is posted on the

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				website and a link is sent to the providers through e-mail. (Written response 05/28/20) **05/28/20** – Quarterly Community Provider Network (CPN) Bulletin has a section about the Grievance Process. (CCHP Provider Bulletin, Volume 17, Issue 2, Summer 2019, p.9) states "Complaints regarding providers of CCHP should be sent to CCHP for resolution." The MCP's written response (05/29/20) confirmed September 17, 2029 distribution. **This finding is closed.**
4.2.1 Develop and implement policies and procedures to monitor the quality of linguistic services provided by multilingual staff for propriety and effectiveness.	4.2.1 Member Services Policy has been modified to ensure the quality of linguistic services provided by Spanish speaking staff propriety and effectiveness. 4.2.1 Culture and Linguistics policy has also been revised to clarify monitoring activities.	Policy CL20.005 MS 8.001	MS. 8.001 Policy And CL20.005 will be approved 10/24/29	**10/21/19** – The following documentation supports the MCP's efforts to correct this deficiency: - Policy & Procedure "MS 8.001" commits the MCP to monitor the quality of linguistic services provided by multilingual staff for propriety and effectiveness. Correspondingly, retrain when issues are identified. (Section I, F (10))

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				- Policy & Procedure "CL 20.005: Assessment of Linguistic and Cultural Competencies" was revised to include section on monitoring the quality of linguistic services by multilingual staff. "CCHP's policy is to assess staff initially and monitor their performance in the Yearly Performance Review." Additionally, the MCP evaluates its linguistic services by looking at the grievances and complaints to identify grievances related to the quality of linguistic services provided by multilingual staff. **This finding is closed.**
4.3.1 Develop and implement procedures to ensure Business Associates report breach or security incidents within required timeframes. Implement policies and procedures to take prompt corrective action on Business	4.3.1. CCHP has amended ADM1.039 to ensure that all business associates shall report breaches or security incidents within required timeframes and that CCHP shall take prompt corrective action on business associates to correct any deficiencies. ADM1.039 has also been amended to include the DHCS Contract Manager contact	4.3.1 ADM1.039 Reporting HIPAA Events Rev 101019	October 2019	**10/21/19** – The following documentation supports the MCP's efforts to correct this deficiency: - A draft Policy & Procedure (10/10/19) "ADM 1.039: Reporting of Improper Disclosures" was revised to include notification to three required entities: - The DHCS Medi-Cal Managed Care Division Contracting Officer, - The DHCS Privacy Officer, and

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
Associates to correct any deficiencies.	information.			- The DHCS Information Security Officer. **07/05/20** – The following additional documentation submitted by the MCP supports its efforts to correct this deficiency: - Updated P&P "ADM 1.039: Reporting of Improper Disclosures" was revised to include notification to three entities at required timeframes. Revised P&P describes the monitoring processes of its Delegate: "CCHP will utilize a tracking tool to record compliance with reporting timeframes measured from the date of discovery by CCHP or our subcontracted Business Associates. Any inconsistencies with reporting timeframes will be discussed with Kaiser, our delegated subcontractor, twice a month in CCHP's Compliance meeting that meets on the second and fourth Monday of every month. The tracker deficiencies are a standing discussion item to be discussed with the subcontractor. CCHP's Compliance meeting will also include staff training on the

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				tracking system, updates on new privacy cases, and for training on how to enter data correctly into the tracking tool." (Revision 07/05/20) **06/23/20** – The MCP submitted the updated tracking log: "2020 Tracking Tool Breaches and Incidents" to demonstrate the process for tracking the Delegates reporting of HIPAA incidents to DHCS and the MCP's oversite of the process. Columns G & H added to follow the reporting of the Delegate to the MCP. **This finding is closed.**
4.3.2 Implement policies and procedures to ensure the Program Contract Manager and Information Systems Officer are included in notifications to DHCS.	ADM1.039 has been amended to include the DHCS Contract Manager contact information. The IS Officer information is already in the policy.	4.3.2 ADM1.039 Reporting HIPAA Events Rev 101019	October 2019	**10/21/19** – The following documentation supports the MCP's efforts to correct this deficiency: - A draft Policy & Procedure (10/10/19) "ADM 1.039: Reporting of Improper Disclosures" was revised to include notification to three required entities: - The DHCS Medi-Cal Managed Care Division Contracting Officer, - The DHCS Privacy Officer, and

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				- The DHCS Information Security Officer. **02/21/20** – the MCP submitted a report of suspected security incidents. (01/20/20 – 02/24/20) The report covers post-implementation dates to gage the results of implemented Corrective Action Plan. The MCP is tracking its reporting data to required entities. These include the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer. (Contract Amendment 02 XIV, Exhibit G, (3)(H)(1)) **03/04/20** - The MCP confirmed that the compliance process is being monitored by the MCP's Director of Compliance and government Relations to ensure the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer are included in notifications to DHCS. (MCP's written response 03/04/20) **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
4.3.3 Implement policies and procedures to ensure verification of identity for all employees and maintain documentation of background checks performed including, but not limited to, persons from outside staffing agencies, subcontractors and county employees.	4.3.3 CCHP will follow the personnel policies and procedures of the Health Services Division for all hiring of new employees and subcontractors. Provider Relations policy requires that all clinicians provide a copy of their clinical license and will do the background check. New employees are required to provide a copy of their California Licenses which is kept in their personnel file maintained by their managers. Health Services Division enacted a new personnel policy for finger printing and complete adherence will be follow by CCHP Managers. In accordance with Contra Costa County HR Department policy fingerprinting information on all County employees are held in that department. Upon request by auditors CCHP will coordinate with HR and request copies of Fingerprinting documentation.	4.3.3 216PM Reference Checking, License Verification, Pre-employment LiveScan Fingerprint Clearance CR 11.016 Credentialing License CCHP Staff	October 2019	**10/21/19** – To address this deficiency the MCP took the steps described in Action Taken column and provided the following documentation to support its efforts to correct this deficiency: - The P&P 216PM "Reference Checking, License Verification and Pre-employment LiveScan Fingerprint Clearance" (Review 07/2010) provides guidance to supervisors in responding to reference checks from other employers, checking references on current County employees or new hires, verification of primary source license, and pre-employment fingerprint clearances. - The P&P CR.11.016 "Credentialing Licensed CCHP Staff" requires all staff to pass Pre-Employment Screening. (Approved 02/11/19) "Prior to employment at Contra Costa Health Plan (CCHP), all licensed staff, full time, part time, permanent and temporary employees, agency temps, and consultants will be subject to and successfully pass Pre-

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				Employment Screening which includes pre-employment background investigation and other requirements that have been identified as appropriate for the position. Contra Costa County Human Resources/Personnel are responsible for notifying applicant to obtain fingerprinting. Results of Pre-Employment Screening are received by Health Services Personnel. (Contra Costa County Administrative Bulletin 415) Issues with the Pre-Employment screening are brought to the attention of the Hiring manager for further evaluation. Background checks on all persons having access to protected health information (PHI) are required as a condition of any type of employment. This includes but is not limited to persons from outside staffing agencies and subcontractors to prevent unauthorized access to PHI." The MCP uses Provider Maintenance Information System (PMIS) database for tracking and updating purposes: "A staff credentials file will be created

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				to store the documentation. During new employee orientation, the County Health Services Department's Confidentiality Policy and Statement will be reviewed. The employee will sign and date a second copy of this policy and the signed copy will be placed in the credential file. As a credential expires, a request will be generated by PMIS and forwarded to the appropriate staff person to request the current license. Noncompliant staff will be brought to the attention of the staff's supervisor for further action." **06/01/20** – The MCP submitted additional documentation to further support its evidence of continues monitoring: - The MCP's response (06/01/20) confirms the MCP's Credential unit e-mails the managers quarterly for updates and runs a monthly license expirable report. Obtains the current license form the appropriate website. - A sample of monthly expirable report "CCHP Staff License Roster"

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				(02/06/20) demonstrates monitoring procedures for verification of the Staff licenses described in CR11.016. P&P "CR 11.016" commits the MCP to the following: "Once a quarter, credential staff will contact the supervisors of each unit to review names of licensed staff in their unit to ensure all new hires have sent in their California ID and/or Federal ID and professional license and to close out licensed staff that have left employment at CCHP." **2020 Medical audit revealed repeat finding 4.3.1** **02/04/21** - The following documentation supports the MCP's efforts to correct this deficiency: - CCHP has compiled the current list of all the active CCHP staff and working with HSD on accessing those records and getting the checklist that Health Services Division uses to coordinate with County Human Resources that show the Background Check was completed.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				- CCHP is requesting all Supervisors to look in their unit files and see whether they have information from NEO Gov and any Background Check Documentation. - A Sample form "CC Notification to Manager from Health Services Personal." This notification is from the County Health Services Personal to the hiring manager. This form will be used as a confirmation of the background process completion. (MCP's submission 01/29/21) **02/16/21** – The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - New Policy and Procedure, "2021-1: CCHP Personnel Hiring and On-Boarding" (01/01/2021) outlines a background check procedures and commits the MCP to a thorough documentation. - A draft MOU (01/01/21) between CCHP and Health Services Division

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				Personnel Office (HSD). HSD/Personnel Department shall: • Ensure that every CCHP employees has the Background Check and will notify the CCHP CEO and or Personnel Staff via email that the Background Check is completed. • Provide CCHP documents that support that a Background Check has been completed. CCHP's Responsibilities: • Contact the HSD/Personnel Clerk if the Background Paperwork has not been forwarded to the CEO • Monitor and track each new employee to ensure a copy of HSD Background Check Checklist they use with County HR has been received • CCHP will do a 100% audit of its staff and make sure the Background Check information is in their personnel file in Administration **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
5. Quality Management				
5.1.1 Develop and implement policies and procedures to ensure that the Plan's governing board reviews and approves the Quality Improvement Program Description, Quality Program Work Plan, and the Quality Improvement Evaluation.	5.1.1 The annual documents were presented to our governing body in March, but there was not a quorum to officially approve it. It was approved by the JCC on September 13. We have updated the Program Description to specify that the documents should be approved in the first quarter. We also had a new approval process approved at JCC to get documents approved in advance in case there is no quorum.	5.1.1 See page 9 of Quality Program Description 5.1.1 JCC Packet Excerpt	5.1.1 Documents Approved 9/13/19; Program Description updated 10/14/19. New approval process 9/13/19	10/21/19-The following documentation supports the MCP's efforts to correct this finding: - 2019 Quality Program Description which has been amended to include on page 9, an outline of the review process which will take place the first quarter of the year in addition to allowing documents to be distributed electronically in advance of the meeting, if a decision is not reached in the meeting this allows for review and later outside approval. - JCC Packet Excerpt Proposal as confirmation that electronic voting has been enabled to ensure that those not present for the Q1 meeting can ensure approval of JCC Minutes and Quality Plans. **This finding is closed**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
5.1.2 Develop and implement policies and procedures to ensure receipt and review of delegated QI activity reports at least quarterly.	5.1.2 Revised Policy CR11.008 to reflect specific timeframes for submission and review of delegated reports. Draft Policy 9.830 also contains delegated reporting requirements. Delegated credentialing agreements will need to be updated with the revised language.	Revised Policy CR11.008 and draft Policy 9.830	12.31.19	**10/21/19** – The following documentation supports the MCP's efforts to correct this deficiency: - Revised P&P, "CR 11.008: Oversight of Delegated Credentialing and Re-credentialing" (10/19) which has been revised to include a section on addressing its delegates' quarterly reporting requirements. - Amended "Delegated Credentialing Agreement" (03/06/20) which outlines that the MCP shall maintain oversight and conduct reviews and audits of Organization credentialing and re-credentialing activities to monitor their effectiveness on an annual basis. MCP will conduct site visits as required or needed. **06/01/20** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: - Monitoring Tool, "Delegated Report Matrix", (2020) as evidence that the Plan is ensuring receipt of all quarterly credentialing activity

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				reports. **This finding is closed**.
5.1.3 Develop and implement policies and procedures to communicate federal, state, contract, or DHCS requirements to its subcontractors and delegated entities.	5.1.3 Our CCHP Requirements Amendment contractually obligates all subcontractors. CCHP has developed PA9.830 to ensure that all subcontractors comply with this requirement.	PA 9.830	12/31/19	10/21/19 – The following documentation supports the MCP's efforts to correct this deficiency: - Policy, "PA 9.830: Sub Contractual Relationships and Delegation" (09/13/19) which outlines the MCP's responsibility for ensuring that their subcontractors and delegated entities comply with all applicable state and federal laws and regulations, contract requirements and reporting requirements. **This finding is closed**
5.1.4 Develop and implement policies and procedures for imposing financial sanctions on subcontractors and	5.1.4. CCHP has developed PA9.830 to ensure that all subcontractors comply with this requirement.	PA9.830	12/31/19	10/21/19 – The following documentation supports the MCP's efforts to correct this deficiency: - Policy, "PA 9.830: Sub Contractual Relationships and Delegation" (09/13/19) which outlines the MCP's

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
delegated entities. Develop and implement policies and procedures for reporting significant non-compliance, imposition of corrective action, financial sanctions of subcontractors, and delegated entities to the Plan's MCOD Contract Manager within three business days.				responsibility for reporting any significant instances of non-compliance, imposition of corrective actions, or financial sanctions pertaining to their obligations under the contract with DHCS to their MCOD contact managers within three business days of discovery or imposition. **This finding is closed**
5.1.5 Revise and implement policies and procedures to collect and review all delegates' ownership and control disclosure information.	5.1.5. CCHP has developed PA9.830 to ensure that all subcontractors comply with this requirement.	PA9.830	12/31/19	**10/21/19** – The following documentation supports the MCP's efforts to correct this deficiency: - The MCP developed Policy, "PA 9.830: Sub Contractual Relationships and Delegation" (09/13/19). The Policy states that subcontractors are required to provide written disclosure of information on subcontractors'' ownership and control. The review of ownership and disclosures applies to subcontractors contracting with a Plan. CCHP shall collect and review

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				their subcontractors' ownership and control disclosure information as set forth in 42 CFR 455.104. **05/22/20** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: - Standard Operating Procedure, "Review of Contract Disclosure Forms" (05/21/20) as evidence that the MCP identifies the process for the Contracts team to review the Contracts forms such as the Disclosure of Ownership & Management Information Statement (Ownership form) for completeness prior to moving forward with the initial and Renewal Contract Process. - Samples, "Contra Costa Health Plan Disclosure of Ownership & Management Information Statement" (2019-2020) provides evidence the MCP ensures this form is correct and complete. - An email (05/22/20) clarifying that the MCP has the ownership and

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				disclosure documents on all current contractors electronically. MCP also sends out the form with every renewal of an MOU and county contract. MCP is in the process of converting all MOU's to contract and the ownership and disclosure documents forms are sent to the contractors at that time. **This finding is closed.**
5.1.6 Revise delegation agreements to ensure the Plan's oversight, monitoring, evaluation processes, and the delegates' responsibility to report findings and actions quarterly are in writing.	5.1.6. CCHP is currently reviewing all delegation agreements to ensure that the delegate's responsibility is specified to report in writing any applicable quarterly reports.		12/31/19	**05/20/20** – The following documentation supports the MCP's efforts to correct this deficiency: - Amended "Delegated Credentialing Agreement" (03/06/20) which specifies the MCP's oversight, monitoring, evaluation process, and the delegate's responsibility to report findings and actions quarterly to the MCP. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
5.2.1 Develop and implement policies and procedures to ensure training for all new providers is conducted within 10 business days.	5.2.1 CCHP already has PA9.816 that ensures new providers are trained within 10 business days. CCHP will review all 6 delegated agreements to ensure that new Provider Training is addressed.	PA9.816	12/31/19	**05/21/19** – The following documentation supports the MCP's efforts to correct this deficiency: -Revised P&P, PA 9.816 – Provider Training (10/19) that requires onsite orientation provided to new providers at the time of initial Facility Site Reviews during the credentialing phase. Ongoing training is provided throughout the year as updates are made available to the Provider Manual, etc. Signed attestations are required. Online training also requires signed attestations. Additional ongoing training is provided during quarterly community provider meetings. - Monitoring Log, "CCHP and CCRMC New Provider Training Log" (05/01/19 – 05/21/20) as evidence that the MCP has a monitoring system in place to track completion of provider training within the required timeframe and ensure receipt of signed/dated attestations. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
5.2.2 Develop and implement policies and procedures to ensure delegated agreements specify all delegated activities, obligations, and related reporting responsibilities; and ensure they are performed.	5.2.2 Review of the AODS MOU shows that it does specify delegated reporting responsibilities, including UM Summary report due 2/28, 5/31, 8/31 and 11/30. CCHP will be ensuring that the delegate complies with these timeframes or will be subject to CAP at our next audit. CCHP does have draft PA9.830 that ensures that delegated providers have agreements specifying delegated reporting obligations and has revised CR11.008.	PA9.830 CR11.008	12/31/19	**10/21/19** – The following documentation supports the MCP's efforts to correct this deficiency: - Revised P&P, "CR 11.008: Oversight of Delegated Credentialing and Re-credentialing/Contra Costa Health Plan Delegated Credentialing Agreement" (10/2019) which has been amended to address the obligation of its subcontractors to provide a CCHP health plan orientation within 10 (ten) business days of being placed active in the network and prior to performing services. At a minimum, the orientation must include a link to the provider manual and an attestation it has been reviewed. - Monitoring Log, "CCHP and CCRMC New Provider Training Log" (05/01/19 – 05/21/20) as evidence that the MCP has a monitoring system in place to track completion of provider training within the required timeframe and ensure receipt of signed/dated attestations. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
6. Administrative and Organizational Capacity				
6.1.1 Develop and implement policies and procedures to conduct an evaluation of classes made available to members.	6.1.1 Health Education policy has been updated to state that we will ask all entities providing classes for information to evaluate the effectiveness of those classes. We will make this part of the delegation oversight process.	6.1.1 Wright Health Coaching Groups Clinical Outcome Data Policy HE19.005	6.1.1 Policy to be approved 10/24/19	**10/21/20** - The following documentation supports the MCP's efforts to correct this finding: - Policy HE 19.005 updated to include assessment of health education classes provided by delegates as a part of annual delegation audits. - Wright Health Coaching Groups Clinical Outcome Data serves as evidence of evaluation of health education classes. **This finding is closed.**
6.2.1 Implement policies and procedures to identify and report overpayments to the State.	6.2.1 Revised the claims overpayment policy. Implement new work flow.	6.2.1 Policy CSU4.159e Recovery of Provider Overpayment	11/1/19	**10/21/19** - The following documentation supports the MCP's efforts to correct this finding: - 6.2.1 Policy CSU4.159e Recovery of Provider Overpayment was revised to clarify the MCP's procedure on reporting overpayments. - Overpayment workflow effective 11/1/19 details MCP's new

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				procedure for reporting overpayments to DHCS. **2/4/20** - The following additional documentation supports the MCP's efforts to correct this finding: - Refund Report 2019 which is submitted to DHCS to report provider overpayments **This finding is closed.**
6.2.2 Implement policies and to establish administrative and management arrangement or procedures to prevent FWA.	6.2.2. CCHP has amended ADM1.006 to clarify the criteria used to determine a reportable event when presented with a suspected versus actual fraud, waste or abuse event.	6.2.2 ADM1.006 Fraud Policy	October 2019	10/21/19-The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, Policy Number: ADM1.006, Title: Anti-Fraud Program (11/19/20) which has been amended to include a section on the regularly scheduled meeting which will be occurring quarterly of the Anti-Fraud Unit/Compliance Fraud Subcommittee. In addition, to written criteria to determine suspected and actual fraud. As well as detailed elements and

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				components of fraud to properly manage each case. (Page 2-3) 11/20/19-The following documentation supports the MCP's efforts to correct this finding: - CCHP Meeting Agenda, (11/04/19) provides evidence of documented review and discussion of the Anti-Fraud policy, confirmation of staff training, in addition to the review of the suspected and confirmed fraudulent activity list which has been integrated into the Quarterly Reporting. - BIM/CFS Meeting Minutes (11/4/19) which provide evidence of overview and in-depth training and discussion of P & P of Medi-Cal Fraud as well as a chart outlining attendees. **This finding is closed**

Submitted By: **Original Signed by Sharron Mackey, M.H.S., M.P.A.**

Title: **Chief Executive Officer**

Organization: **Contra Costa Health Plan**

Date: **October 18, 2019**