DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

September 13, 2024

Ronda Arends, Director of Compliance and Government Relations *Via E-mail*
Contra Costa Health Plan
595 Center Avenue, Suite 100
Martinez, CA 94553

RE: Department of Health Care Services Medical Audit

Dear Ms. Arends:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Contra Costa Health Plan, a Managed Care Plan (MCP), from August 7, 2023 through August 18, 2023. The audit covered the period from July 1, 2022, through June 30, 2023.

The items were evaluated, and DHCS accepted the MCP's submitted Corrective Action Plan (CAP). The CAP is hereby closed. The enclosed documents will serve as DHCS' final response to the MCP's CAP. Closure of this CAP does not halt any other processes in place between DHCS and the MCP regarding the deficiencies in the audit report or elsewhere, nor does it preclude the DHCS from taking additional actions it deems necessary regarding these deficiencies.

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

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

Sincerely,

[Signature on file]

Lyubov Poonka, Chief
Audit Monitoring Unit
Process Compliance Section
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

Enclosures: Attachment A (CAP Response Form)

cc: Stacy Nguyen, Chief *Via E-mail*
Managed Care Monitoring Branch
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

Grace McGeough, Chief *Via E-mail*
Process Compliance Section
Managed Care Monitoring Branch
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

Anthony Martinez, Lead Analyst *Via E-mail*
Audit Monitoring Unit
Process Compliance Section
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Arianna Ngo, Unit Chief *Via E-mail*
Managed Care Contract Oversight Branch
DHCS – Managed Care Operations Division (MCOD)

Lissette Valle, Contract Manager *Via E-mail*
Managed Care Contract Oversight Branch
DHCS – Managed Care Operations Division (MCOD)

ATTACHMENT A
Corrective Action Plan Response Form

Plan: Contra Costa Health Plan
Audit Type: Medical Audit

Review Period: 7/1/22 – 6/30/23
On-site Review: 8/7/23 – 8/18/23

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

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

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

DHCS will communicate closely with the MCP throughout the CAP process and provide technical assistance to confirm that the MCP offers sufficient documentation to correct deficiencies. Depending on the number and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates.

1. Utilization Management

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
1.2.1 Timeliness of Utilization Management Decisions The Plan did not render decisions for prior authorization, concurrent review, and retrospective review requests within the required timeframes.	• The Plan has revised UM Policy 15.015a to better define the timelines, processes, training, auditing and remediation that is involved with respect to the timeliness of utilization management decisions. • The Plan has also created new desk procedures to be utilized by Auth/UM Staff (HPARs, nurses, and physicians) with respect to timeliness of utilization management decisions. • Training on these policies and procedures are ongoing, auditing will occur regularly, and remediation will occur at the individual or group level, as appropriately.	• UM Policy 15.015A - Timeliness of Utilization Management Decisions • Desk Procedure – Decision Due Date Desk Procedure • Desk Procedure – UM HPARs Turn Around Time (TAT) Review Desk Procedure • Desk Procedure – UM Nurses Turn Around Time (TAT) Review Desk Procedure • Desk Procedure – Frequency of Concurrent Review • Desk Procedure – UM Physicians Turn Around Time (TAT) Review Desk Procedure	March 2024	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policy 15.015a Timeliness of Management Decisions was revised to better describe the MCP's training which includes the review of relevant policies, procedures, All Plan Letters (APLs), and relevant sections of the MCP's contracts and shadowing of fellow staff members. The MCP's auditing is better defined to include the monthly review of at least 5 referrals of each referral type (urgent/expedited, concurrent, routine, retrospective). (1.2.1 15.015a Timeliness of UR Decision and Communication) • Desk procedure - Decision Due Date, Desk procedure - UM HPARs Turn Around Time (TAT) Review Desk Procedure, Desk Procedure - UM Nurses Turn Around Time (TAT) Review Desk Procedure, Desk Procedure - Frequency of Concurrent Review, and Desk Procedure - UM Physicians Turn Around Time (TAT) Review Desk Procedure were developed by the MCP to clarify timeframe requirements, training and ongoing monitoring for all lines UM staff.

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				TRAINING • Slide deck from 4/4/24 UM Staff meeting demonstrates the MCP trained UM staff on the need for transplant-related referrals to be processed as urgent. (1.2.1 Auth-UM April 2024 Update) **MONITORING AND OVERSIGHT** • February Urgent Authorization Audits for retro, concurrent, routine and transplant referrals demonstrate the MCP is auditing referrals for meeting the required turnaround time. • March 2024 Transplant Audit demonstrate the MCP is auditing transplant related to verify they are being categorized as urgent on a monthly basis. (1.2.1 March 2024 Transplant Audit) **The corrective action for finding 1.2.1 is accepted.**
1.2.2 Utilization Management Criteria for Dental Anesthesia The Plan denied medically necessary general anesthesia	• The Plan has revised UM Policy UM 15.051 Dental Services – Intravenous Moderate Sedation and Deep Sedation/General Anesthesia Coverage to be in alignment with Medi-Cal criteria	UM Policy 15.051 - Dental Services – Intravenous Moderate Sedation and Deep Sedation/General Anesthesia Coverage	January 2024	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
for dental services using Utilization Management (UM) criteria that were more restrictive than Medi-Cal criteria indications described in APL 15-012.	indications described in APL 23-028, which supersedes APL 15-015. All Authorizations/Utilization Management staff (HPARs, nurses, physicians) has received information and training regarding the policy change and policy application			• UM Policy 15.051 - Dental Services – Intravenous Moderate Sedation and Deep Sedation/General Anesthesia Coverage has been updated to be in line with APL 23-028. The policy does not require dental provider chart documentation for approval per APL 23-028. **MONITORING AND OVERSIGHT** • Feb 2024 dental anesthesia referrals audit demonstrates the MCP is actively auditing its dental anesthesia referral for correct determination. • IRR Results Summary 2024 Q1 demonstrate the MCP includes dental anesthesia cases in its IRR reviews. (1.2.2 MD IRR results summary 2024 Q1). • UM Physicians Meeting May 22, 2024 PowerPoint demonstrates dental anesthesia cases are included in the MCP's IRR review and the results are discussed in MCP's Physician Meeting. (1.2.2 MD IRR results summary 2024 Q1). **The corrective action for finding 1.2.2 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
1.5.1 Nondiscrimination Notice and Language Assistance Taglines The Plan did not ensure its delegate, Contra Costa Behavioral Health Services, sent NDN and LAT information to members with all written notices pertaining to rights or benefits in accordance with APL 21-004. The Plan did not ensure its delegate, Contra Costa Behavioral Health Services, sent NDN and LAT information to members with all written notices pertaining to rights or benefits in accordance with APL 21-004.	The Plan has revised UM Policy 15.015a to include Member Notification language addressing authorization decisions and member notification by delegates, as well as removing outdated attachments. The Plan has centralized letter revision and maintenance under CCHP and embedded all attachments into letterhead to reduce the opportunity for errors and omissions of updated required language including NDN and LAT. The Plan has created a desktop guide to define the procedure for updating decision letters as required to maintain compliance with DHCS requirements. The Plan has conducted an annual review of its delegate, Contra Costa Behavioral Health Services (BHS) and created a desktop guide to document and provide guidance on conducting an annual audit of BHS delegation. The Plan initiated and hosts monthly	UM15.015a Timeliness of UR Decision and Communication Redline 2.2024.pdf CCHP Desk Procedures_Letter Maintenance .pdf BHS ANNUAL AUTH 1.pdf 2023 CCHP-BHS Annual Survey Final Report.pdf BHS Access-CMU Audit Desk Procedure 02-2024.pdf BHD CAP Oversight Desk Procedure 02-2024.pdf 2024-02 – Agenda.pdf 2024 CCHP BHS Monthly Coordination Agenda.pdf	March 2024	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • "1.5.1 UM15.015a Timeliness of UR Decision and Communication" demonstrates the Plan has revised policies & implemented new desk procedures that outline the monthly auditing process & training process for deficiencies found around written notices where the NDN & LAT information is included. (Member Notification & Internal Training, Page 5) • The Plan stated it has embedded all attachments into Plan letterhead to reduce the opportunity for errors & omissions of updated required language including NDN & LAT. (See 1.5.1 Statement regarding 1.5.1) • "1.5.1 BHS ANNUAL AUTH 1" demonstrates that the Plan revised its template to include letterhead & required attachments for authorizations. The Plan is responsible for letter revisions & letter maintenance – allowing for the reduced opportunity for errors & omissions of updated required language. (BHS ANNUAL AUTH 1, Network Provider – Authorization Letter)

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	coordination meetings and quarterly delegation agreement (MOU) meetings for ongoing oversight and monitoring and policy updates. BHS presents updated program description and workplan annually at Quality Council meetings.	2024 BHS and CCHP Quarterly MOU Meeting Agenda.pdf		**TRAINING** • "1.5.1 2024 BHS and CCHP Quarterly MOU Meeting Agenda" demonstrates that the Plan addressed the DHCS audit findings & the updated program description. Additionally, the Plan created standing agenda item during its Quarterly Meeting • "1.5.1 2024 CCHP BHS Monthly Coordination Agenda" demonstrates that the Plan addressed the DHCS audit findings & Monitor utilization for PQI during its monthly coordination meeting. • "1.5.1 2024-02 – Agenda Quality Council Meeting" demonstrates the Plan addressed the DHCS audit findings & its updated program description & workplan annually at Quality Council meetings. **MONITORING AND OVERSIGHT** • "CCHP Desktop Procedures_Letter Maintenance" demonstrates the Plan's centralized letter revision & maintenance process. • "DHCS CAP Oversight Desk Procedure" demonstrates the Plan's self-monitoring component, periodically reviewing the essential operations & verifying that the deployed corrective action is effective & has

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				eliminated deficiencies. (DHCS CAP Oversight Desk Procedure, DETAILS, page 1) • "BHS Access-CMU Delegate Audit Desk Procedure" demonstrates the Plan has an annual audit implemented of BHS delegation. Policy states it is the Plan's responsibility to schedule the annual oversight audit of BHS including documentation review & interviews. The Plan generates a summary audit report, that includes potential findings, to share back to BHS for opportunities to improve. (BHS Access-CMU Delegate Audit Desk Procedure, page 1) • "1.5.1 2023 CCHP-BHS Annual Survey Final Report" demonstrates the implementation of the annual audit, compiling a report on the Annual Survey of BHS – UM. The report is created after the review & survey of services delegated from the Plan to BHS. The report highlights that each letter template provided during the audit period, included the required attachments as part of the document, including NDN & LAT. (1.5.1 2023 CCHP-BHS Annual Survey Final Report, page 5) **The corrective action plan for finding 1.5.1 is accepted.**

2. Case Management and Coordination of Care

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
2.1.1 Required Components of the Initial Health Appointment (IHA) The Plan did not ensure that providers documented all required components of an IHA.	• The plan will conduct education with providers on the Initial Health Appointment, covering all required components. Education will be during the quarterly network trainings and in the quarterly newsletter. • The plan will educate providers on clinical practice guidelines, ensuring the USPSTF are reviewed. This will take place during the quarterly network training and provider newsletter. • The plan will conduct audits and facility site reviews and medical record reviews on providers, reviewing for required components. • The plan will provide feedback summaries to providers on required components of the initial health appointment. For actions not already completed, the Plan has initiated remedial action and aims to achieve satisfactory compliance by the dates indicated.	• Quarterly provider network newsletter • Quarterly provider network training • Audit tool Feedback to providers	Feb. 2023, Dec. 2023, Apr. 2024, May 2024	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • "2.1.1 QM14.701 (2024-02-13) Initial Health Appointment" did not require any revisions by the Plan & demonstrates the Plan's IHA process, outlining who is responsible, what needs to be measured, documented & timeline of completion. (POLICY, 1. - 4., pages 1-2) **TRAINING** • "2.1.1 CPN Care Matters Provider Bulletin 4th Qtr Winter 2023 – FINAL" demonstrates the Plan conducted education & will continue to educate through its quarterly network bulletin, reminding providers of their responsibility to fulfill the IHA requirements within the first 120 days & educating providers on the components of the IHA. (IHA Training: CPN Care Matters, IHA, page 4) • "2.1.1 Q4 2023-10-31 USPSTF Training Slides" demonstrates the Plan's provider network training that was implemented, educating providers on the

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				components of an IHA & the USPSTF guidelines. (USPSTF Training: Q4 2023-10-31, slides 57-58) **MONITORING AND OVERSIGHT** • Sample tracker "IHA Audit Tool" demonstrates that the Plan is monitoring the required components of an IHA. (2.1.1 IHA Audit Tool) • "Primary Care Provider-Medical Record Review Tool" demonstrates the Plan has updated its review tool to include the components required to document in an IHA. The review tool is used to self-monitor, verifying all components have been completed or documented. (Medical Record review tool and standards abridged - IHA specific) • "CAP Notification" demonstrates the Plan has updated its template to include all components of an IHA, verifying that components have been completed or have been documented for any other reason. (Sample FSR CAP, pages 3-4) **The corrective action plan for finding 2.1.1 is accepted.**

3. Access and Availability of Care

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
3.1.1 Extending Appointment Timeframes Standards The Plan did not monitor providers to ensure extensions of member appointment timeframes are appropriately documented in the member's medical record, including the reason the extension will not be detrimental to the member's health.	• The plan will conduct training with providers on timely access standards, specifically on extending appointment timeframes. This training will occur at the quarterly providing trainings and in the quarterly network newsletter. • The plan will conduct audits on a sample of charts, ensuring that if the appointment time was extended, it was documented in the medical record indicating the extension is not determinantal to the member's health. • The PQI and Grievance staff will be educated on the extended appointment timeframes and review the medical record that this documentation is included when there were grievances or PQIs related to access or delay in care. For actions not already completed, the Plan has initiated remedial action and aims to achieve satisfactory compliance by the dates indicated.	• Quarterly provider network training presentation • Quarterly newsletter Audit tool	Feb. 2023, Dec. 2023, Apr. 2024, May 2024	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated Policy 14.101, "Timely Access to Care Standards" (04/24) has been updated to include quarterly monitoring through specialty audit reviews. The Plan will review medical records and if timely access standards are not met, the Plan will review if the extended appointment timeframe was documented in the medical record and that a longer timeframe will not have a detrimental impact on the member's health. Non-compliant Providers will be educated and resurveyed in subsequent quarters. Education on extending appointment timeframes will occur during the Facility Site Reviews, Provider Network Training, and Network Newsletters. **TRAINING** • Power Point, "Q3 2023 Provider Network Training" (07/25/23) demonstrates the Plan presented slides in regard to the components of extended appointments through provider network newsletter and provider network training. This

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				training was presented to the entire contracted CCHP Provider Network. Future training dates have been scheduled quarterly for 2024. • Bulletin, "Provider Network NEWS, Volume 21, Issue 4" (January 2024) demonstrates the Plan has reminded Providers on the importance of documenting extended timeframes for timely access within the Member's medical record and that a longer timeframe will not have detrimental impact on the Member's health. In addition, Providers are also reminded that this documentation must be available to DHCS upon request. • Form, "Provider Office Training Attestation" (01/17/24) demonstrates the Plan includes in their training module the importance of documenting extended timeframes for timely access within the Member's medical record and that a longer timeframe will not have detrimental impact on the Member's health. (3.1.1 CCHP QC Minutes 2024-05 DRAFT.docx and 3.1.1 2024-05 - QC Presentation.pptx) • Presentation, "CCHP Update" (07/15/24) demonstrates the CMO conducted a presentation to one of the Plan's largest provider groups,

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				emphasizing the importance of timely access and the need for proper documentation within the medical record ensuring the feedback loop between administrative staff making appointments and clinical staff able to make medical determinations. • Quality Council Drafted Meeting Minutes and Quality Council Presentation, (05/14/24) which demonstrates the Plan discussed shortening or extending appoint timeframes as clinically appropriate and assessing whether it is documented in medical record that extension is not detrimental to the member's health. • Quality Council Meeting Minutes, (08/13/24) demonstrates that the Timely Access Audit Report for Q2 2024 was reviewed and approved by the Quality Council. **MONITORING AND OVERSIGHT** • Audit Template, "Specialty Audit Template" (12/23) which demonstrates the Plan monitors if timely access standards are not met, the Plan will review if the extended appointment timeframe was documented in the medical record that longer

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				timeframe will not have a detrimental impact on the member's health. • Audit, "Specialty Audit" (Q1 2024) demonstrates the Plan executes a quarterly audit to make certain Providers are being monitored for extensions of member appointment timeframes and are appropriately documented in the member's medical record, including the reason the extension will not be detrimental to the member's health. This Q1 2024 quarterly was performed by the Director of the Clinical Quality Auditing Unit and the team of RN's. The audit team randomly pulled 32 member records. 17/32 members timely access standards were not met. 0/17 members records did not document whether an extended appointment time would not have a detrimental effect to the Members' health. The Plan will conduct further education to providers on timely access standards, so that providers document extended timeframe documentation in the medical record. • Audit, "Timely Access Audit" (Q2 2024) demonstrates the Plan randomly pulled 15 member records. The Plan reviewed the entire

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				medical record to determine if timely access standards were met. If timely access standards are not met, the Plan will assess whether an extended appointment timeframe was documented within the medical record that it does not have a detrimental impact on the member's health. This audit demonstrated 100% of members were compliant with timely access standards, which is above the Plans goal of 70% compliance. • Corrective Action Plan (CAP), "Facility Site Review Survey (FSR) CAP" (12/23) which demonstrates the Plan issues CAPs to Provider's who are non-compliant with the requirement of documenting member's medical records with extensions of member appointment timeframes including the reason the extension will not be detrimental to the member's health. **The corrective action plan for finding 3.1.1 is accepted.**

4. Member's Rights

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
4.1.1 Grievance Identification The Plan did not process and resolve all member expressions of dissatisfaction as grievances.	• Policy & Procedure *MS 8.019 Response to Member Inquiries* has been revised to reflect update in our process regarding calls regarding member bills. • Member Services Management held a staff training on 2/28/2024, focusing on proper grievance identification. Training included case studies from DHCS audit findings. • Member Services Management will implement adhoc weekly monitoring of inquiries on the 2 topics that identified as DHCS audit findings – Billing and Case Management Referrals. Monitoring will take place during the month of 3/2024. Staff who	• Policy & Procedure: *MS 8.019 Response to Member Inquiries* (MS 8.019 Response to Member Inquiries_2024-03-04_DRAFT.doc) • Diagram of workflow for processing calls regarding member bills. (MemberBill_GrievanceWorkflow_2024-03-04.pdf) • Member Services staff training regarding proper grievance identification (Member Services Meeting_2024-02-28.pdf) Meeting Minutes (Unit Meeting Minutes 02-28-2024 v3.doc) • Policy & Procedure: *MS 8.005 Quality Monitoring of the Member Services Department* (MS 8.019 Response to Member Inquiries_2024-03-04_DRAFT.doc)	Feb. 2024, Mar. 2024, Apr. 2024, Jul. 2024	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Revised P&P, MS 8.019, "Response to Member Inquiries" (03/2024) outlines the revised process for handing inquiry calls. If the member expresses dissatisfaction, the MS Counselor will address any immediate needs that they may be able to assist with first; the MS Counselor will then ask the member whether they want to file a grievance. If the member declines to file a grievance, the MS Counselor will issue a letter confirming that the member has declined to file a grievance, but that they can change their minds at any time. Otherwise, the MS Counselor will proceed with the grievance process. • Revised P&P, MS 8005, "Quality Monitoring of the Member Services Department" (03/2024) revised to include the following: After training Member Services staff and implementing a new process or procedure, the Manager or designee will monitor or audit staff performance on a weekly basis for a month. Staff who continue to struggle will be identified, and additional support will be provided.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	continue to struggle will get additional training and will continue to be monitored weekly until they demonstrate 2 consecutive weeks of processing these issues correctly. • Member Services Management will apply DHCS's definition of grievances when conducting our internal quarterly audits on inquiries. For actions not already completed, the Plan has initiated remedial action and aims to achieve satisfactory compliance by the dates indicated.			Weekly monitoring/auditing will continue for those particular staff members until they no longer have findings from the weekly monitoring / auditing for two consecutive weeks. • Workflow, "Member Bill: Grievance Workflow" (03/04/2024) which demonstrates the workflow process when an inquiry is received in regard to a member receiving a bill for services. This workflow includes the roles & responsibilities between Member Services, Appeals & Grievances Department, and Claims. In addition, Per Plan response, the definition in revised P&P, MS 8.019, Page 2, #5 and workflow for grievances is the same regardless of topic. **TRAINING** • Training, "Member Services Staff Training Presentation" (02/28/24) which demonstrates that the Member Services Staff received training in regard to proper grievance identification and included discussion of case studies from DHCS audit findings.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				• Meeting Minutes, "Member Services Unit Meeting Training" (02/28/24) which demonstrates the Plan discussed proper grievance identification. • Training, Member Services Management provided one on one training for staff who did not score 100% in our weekly internal audit. Staff were shown the cases where they are deficient. Training dates were 03/01/24, 03/08/24, and 03/18/24. • Re-Training Grid, "Staff Training – Member Billing Grievance" (03/24) weekly internal audit process and accompanying 1:1 training will continue past the month of March for staff until they score 100% for at least 2 consecutive weeks. The training material used was the 2/28/2024 Member Services Staff Training Presentation. • Training, "Member Services Meeting" (03/28/24) as evidence that the Plan conducted a 2nd all staff training on grievances. Management showed internal weekly audit results and discussed questions or issues staff had with regard to the Member Services process for grievances. In addition, the Member Services management will hold another similar all staff meeting around 4/24/2024. Management may hold a subsequent

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				all staff meeting on grievances in late May, depending on whether the majority of staff begin to perform 100% on the internal audit. **MONITORING AND OVERSIGHT** • Internal Audit, "Billing Issues" (Q1 2024) demonstrates the Plan reviewed 31 billing/claims/financial responsibility CRM inquiries. Out of the 31 CRMs, 30 cases were related to member receiving bills. For 20% of these cases, the staff offered to file a grievance. The Plan did not meet the goal of the staff offering to file grievance for billing issues for Q1 2024. These results were anticipated because the Member Services Department were not trained until February 28, 2024. The Plan does categorize the complaint as a grievance, even if the member declines to file a grievance. • Internal Audit, "ECM-CM CRM Audit" (March, April, and May 2024) demonstrates the Plan is conducting internal audits of ECMs and CRMs with Case Management Referral as the subtopic. The Plan categorizes the complaint as a grievance, even if the member declines to file a grievance. The CRMs are reviewed to see if there were any expressions of dissatisfaction, and if so, whether

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				the staff offered to file a grievance for the member. The Plan will continue the monthly audits until the staff score 100% for 2 consecutive months. **The corrective action plan for finding 4.1.1 is accepted.**

5. Quality Management

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
5.2.1 Ownership and Control Disclosures of Delegates The Plan did not collect and review all required ownership and control disclosure information from its subcontractors.	Contract staff have reviewed the entities Ownership and Disclosure forms. When missing information or errors have been identified, staff have contacted the entity for the required information.	Submitted- Power point Training, Checklist, Policy 9.830-Subcontracts and Delegation, E-mails to UCSF and Stanford.	Continuous; Dec. 2023, Jan. 2024	**TECHNICAL ASSISTANCE** Plan is no longer required to submit any ownership and disclosure information containing Personally Identifiable Information (PII) to DHCS as part of the Corrective Action Plan (CAP). The Plan must continue to ensure subcontractors accurately provide all required information in their disclosures. Additionally, the Plan must review disclosure forms to identify potential conflicts of interest and make subcontractor ownership and control disclosures available upon request, as the information is subject to audit by DHCS. (For additional guidance refer to 4/15/24 DHCS MACC e-mail.) **The corrective action for finding 5.2.1 is accepted.**

6. Administrative and Organizational Capacity

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
6.2.1 Designated Compliance Officer The Plan did not have a designated Compliance Officer responsible for the compliance program.	Appointed a Compliance Officer – Chanda Gonzales in October 2023, updated JCC bylaws and communicated with DHCS on point of contact.	JCC Bylaws, Admin 1.006 policy, org chart, email to DHCS regarding point of contact.	October 2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated P&P, "ADM 1.006: CCHP Fraud Prevention Program" (02/13/24) which states that the MCP's CEO will appoint the Compliance Officer annually. The Director of Compliance can be appointed as the Compliance Officer; however, other qualified individuals can be appointed. At the MCP's quarterly board meetings the Compliance Officer or Director will present a status of the program to include upcoming audits, audit findings and Corrective Action plans. (ADM 1.006 Fraud Prevention Program, Page 1). • Email from the MCP to MCOD Contract Manager (11/08/23) confirming Chanda Gonzales as the MCP's designated Compliance Officer and primary contact. (Email Regarding Point of Contact for Compliance). • Evidence of newly assigned CO coordinating with DHCS and DMHC on all regulatory affairs starting October 2023. (From Att. B, Column H).

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				• The Joint Conference Committee is the governing board for CCHP and the last two JCC meetings Oct/December 2023 Compliance Updates is a standard Agenda item. Fraud Waste and Abuse compliance was reported at both meetings. Appointed Compliance Officer has been coordinating with DHCS and DMHC on all regulatory affairs – Oct 2023. • "Contra Costa Health Plan Succession Plan" (04/01/24) as evidence that the MCP has implemented action steps to demonstrate that the MCP's Compliance Department is staffed at 80%. When staff that submits a resignation, the MCP will submit a Personnel Form to the County to request a replacement. Anytime the Compliance staffing is less than 80%, the MCP's Chief Executive Officer will use the Administration team to assist with compliance duties, as well as reassign Program Managers to assist. The MCP will meet with Compliance staff annually to project retirements with staff that have been with the County for more than ten years. (CCHP Succession Plan). **The corrective action plan for finding 6.2.1 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
6.2.2 Reporting to the Board of Directors The Plan did not ensure oversight of its compliance program, including compliance with the requirements under the Contract.	The Joint Commission Committee is the governing board for CCHP and the last two JCC meetings Oct/December 2023 Compliance Updates is a standard Agenda item. Fraud, waste, and abuse (FWA) was reported at both meetings. CCHP has regular meetings with contract manager at DHCS.	JCC Agenda, minutes, and slides, updated Admin 1.006 policy, email to BOS regarding fraud cases, meeting invite for regular meetings with DHCS contract manager.	September 2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated P&P, "ADM 1.006: CCHP Fraud Prevention Program" (02/13/24) which states that at the MCP's quarterly board meetings the Compliance Officer or Director will present a status of the program to include upcoming audits, audit findings and Corrective Action plans. Semi-annual a FWA written report will be sent to the JCC board. In addition, the Compliance Officer or Director of Compliance will meet with the MCP's Senior Executive team to include the CEO, CMO, COO and Chief Health Equity Officer on the status of FWA and other Compliance updates. (ADM 1.006 Fraud Prevention Program, Page 1). • Agenda and Meeting Minutes, "Contra Costa Health Plan/Board of Supervisors Joint Conference Committee" (09/08/23, 12/08/23) as evidence that the MCP's Compliance Director or Compliance Officer will give an update at the quarterly Joint Conference Committee (JCC). This is a standing agenda item. Also, semi-annually, the MCP will publish a Fraud, Waste, and Abuse Report to the JCC. (JCC Agenda, JCC Meeting Minutes).

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				The corrective action plan for finding 6.2.2 is accepted.
6.2.3 Administrative Capacity The Plan did not maintain sufficient staffing to carry out the effective conduct of the Plan's business activities.	In July of 2023 added two Senior Program Managers, Advanced Level Secretary and Student Intern. In October we added another Senior Program Manager. Recruiting for a Director of Compliance and two Health Plan Evaluators and another Student Intern. Compliance Officer is directly supervising the department until Director of Compliance is hired.	Compliance Org chart, Matrix outlining staff and dates in compliance.	July 2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Written Document, "Contra Costa Health Plan Succession Plan" (04/01/24) as evidence that the MCP has implemented action steps to demonstrate that the MCP's Compliance Department is staffed at 80%. When staff that submits a resignation, the MCP will submit a Personnel Form to the County to request a replacement. Anytime the Compliance staffing is less than 80%, the MCP's Chief Executive Officer will use the Administration team to assist with compliance duties, as well as reassign Program Managers to assist. The MCP will meet with Compliance staff annually to project retirements with staff that have been with the County for more than ten years. (CCHP Succession Plan). • "Compliance and Government Relations / Project Management Organizational Chart" (July 2024) as

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				evidence that the MCP has maintained sufficient staffing to carry out the effective conduct of the MCP's business activities. The MCP has hired and staffed a Director of Compliance in May 2024, two Health Plan Evaluators in June 2024 and July 2024, Compliance Consultant in August 2024, Senior Program Manager in June 2024, and a Student Intern in July 2023. (Compliance PMO Org Chart 2024-07-25). **The corrective action plan for finding 6.2.3 is accepted.**

Submitted by: Contra Costa Health Plan
Title: Compliance Officer

Signed by: [Signature on File]
Date: March 7, 2024