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

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

February 5, 2021

Tyler Haskell, Interim Compliance and Privacy Officer
Santa Clara Family Health Plan
6201 San Ignacio Avenue
San Jose, CA 95119

RE: Department of Health Care Services Medical Audit

Dear Mr. Haskell:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Santa Clara Family Health Plan, a Managed Care Plan (MCP), from March 18, 2019 through March 29, 2019. The audit covered the period of April 1, 2018 through February 28, 2019.

On December 22, 2020, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on July 11, 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,

[redacted]

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: Santa Clara Family Health Plan **Review Period: 4/1/18 – 2/28/19**

Audit Type: Medical Audit and State Supported Services **Onsite Review: 3/18/19 – 3/29/19**

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.

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1. Utilization Management				
1.1.1 – Delegation Oversight The Plan failed to comply with contract requirements to	1. SCFHP will revise the following Delegation Oversight Policies DE.01 "Delegation Oversight", DE.06 "Delegation Audit" and DE.07 "Delegation		1. 10/31/2019	**08/12/19** – The following documentation supports the MCP's efforts to correct this finding: - "Santa Clara Family Health Plan &

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monitor its delegated entity's subcontracting activities. The Plan did not ensure that their delegate's oversight included a comprehensive review and identification of specific problems. The Plan's failure to fully monitor its delegate's administrative activities could have adverse effects on service delivery to Plan members. In addition, the Plan's non-disclosure of the delegate entity's contract violation to the Managed Care Operations Division (MCOD) was noncompliant with DHCS Contract requirements.	Corrective Action" to include a process on reporting to DHCS any significant instances of non-compliance or corrective action pertaining to the Plan's obligation under the Contract within three business days. 2. SCFHP will review and revise Business Associate Agreements (BAA) as warranted to address reporting of privacy incidents. 3. SCFHP has added a standing agenda item for all Joint Operation Committee meetings to communicate State and Federal laws and regulations; contract requirements; reporting requirements; and other DHCS guidance including, but not limited to, APLs, to the delegates. 4. SCFHP will revise the Delegation Oversight Policies, DE.06 "Delegation Audit" and	3. VHP JOC Agenda 7.31.19	2. 12/31/2019 3. Ongoing 4. 10/31/2019	Valley Health Plan Joint Operations Committee (JOC) Meeting Agenda," (07/31/19) which includes a standing agenda item for all JOC meetings to communicate State and Federal laws and regulations; contract requirements; reporting requirements; and other DHCS guidance including, but not limited to, APLs, to the delegates. This current agenda includes a list of released APLs in 2019. **03/03/20** – The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - Audit tool, "2020 Delegate's Monitoring and Auditing of Subcontractors Audit" which includes a section in which the MCP will perform monitoring of its subcontractors. The audit tool includes the MCP's review of the delegate's policies and procedures to monitor, conduct corrective action, and oversight and auditing for compliance with its established

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	DE.07 "Delegation Corrective Action" to ensure the Plan's delegate oversight includes comprehensive review and identification of specific items requiring correction when a delegate does not comply with regulatory and contractual requirements. 5. SCFHP will develop and implement an annual questionnaire to our delegates to inquire if they sub-delegate any of SCFHP's activities. Utilize Corrective Action P&P take appropriate actions when the questionnaire reveals non-compliant areas. 6. SCFHP will develop and implement an Annual Compliance Attestation to obtain a delegate's commitment to comply with DHCS requirements and the contractual obligations between the delegate, the delegate's subcontractors and SCFHP.		5. 12/31/2019 6. 12/31/2019 7. 10/31/2019	standards. - "Medi-Cal Provider Subcontractor Form" which gives delegated entities the opportunity to declare information about subcontractors who are directly contracted with their organization to perform the activities that SCFHP delegates to their organization. - "Delegated Entity Annual Compliance Attestation" which the MCP uses to obtain a delegate's commitment to comply with DHCS requirements and the contractual obligations between the delegate, the delegate's subcontractors and SCFHP. **05/06/20** – The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - Updated P&P, "DE.01 v3: Delegation Oversight" (04/13/20) which has been amended to include reporting to DHCS any activity of the delegate that subcontracts to another

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	7. SCFHP will revise the Plan's audit tool to include the Plan's review of the delegate's monitoring, oversight and auditing of its subcontractors who perform services to the Plan's members.			entity. The Compliance Department will report to DHCS any significant instances of non-compliance or corrective action pertaining to the Plan's obligation under the Contract within three business days. The Compliance Department is also responsible for providing guidance to subcontracted entities on how to handle and report breaches based on the DHCS Contract requirements, State and Federal regulations, and other DHCS guidance including, but not limited to, APLs. - Updated P&P, "DE.06 v3: Delegation Audit" (04/13/20) and "DE.07 v3: Delegation Corrective Action" (04/13/20) which has been amended to include reporting to DHCS any significant instances of non-compliance or corrective action pertaining to the Plan's obligation under the Contract within three business days. - Updated Manual, "Compliance Guide – Delegated Entities" (03/04/20) which includes information

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				on subcontractor ownership and disclosures. Delegated Entities are required to provide written disclosure of information on Subcontractor's ownership and control for SCFHP to review against 42 CFR § 455.104.6. Delegated Entities must make the Subcontractors' ownership and control disclosure information available, and upon request, this information is subject to audit by DHCS. Delegated Entities shall alert SCFHP within three business days upon discovery that a Subcontractor is out of compliance with these requirements, and/or if a disclosure reveals any potential violation(s) of the ownership and control requirements. **This finding is closed.**
1.2.1 - Written Notification to Providers for Prior Authorization The Plan did not consistently notify the provider of a	SCFHP has revised a Pharmacy procedure PH.03.01 "Medi-Cal/HK Prior Authorization Procedure v4" to include a process to ensure prescribers will receive a written notification in cases	• PH.03.01 "Medi-Cal HK Prior Authorization_v5_final.pdf" • 2019 – Failed	February 15, 2019	**08/13/19** – The following documentation supports the MCP's efforts to correct this deficiency: - Updated P&P PH.03.01v5 "Medi-Call/Health Kids Prior Authorization" (revised 02/13/19) demonstrates a

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pharmacy prior authorization decision. The verification study disclosed that the Plan failed to notify prescribing physicians in two pharmacy prior authorization samples due to facsimile failure. The Plan acknowledged that for two samples, provider notification did not occur due to unsuccessful facsimile communication. In addition, the Plan failed to implement a quality assurance process in monitoring for unsuccessful provider notification via facsimile communication. An informal procedure existed which the Plan considered reliable but was determined to be ineffective. The	when the written fax notification to the requesting provider fails. SCFHP provided training on the revised procedure to internal pharmacy department staff.	Fax Sign-In Sheet_02.15.19.pdf • 2019 – Failed Fax Highlighted Training_02.15.19.pdf		written procedure and monitoring mechanism in place to ensure successful fax transmission to providers. (Page 2, F. Notification) - "Pharmacy Failed Fax Training" (02/15/19) with sign-in sheets as evidence that the staff received training. The training material addresses facsimile failure and quality assurance process in monitoring for unsuccessful provider notification. **This finding is closed.**

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Plan did not have a written procedure and monitoring mechanism in place to ensure successful fax transmissions to providers.				
1.2.2 - Inconsistent Application of Medical Necessity Criteria for Pharmacy Prior Authorization The Plan failed to ensure that pharmacy prior authorization decisions are consistent with criteria or guidelines that are supported by clinical principles and processes. In the verification study review, the Plan failed to apply medical necessity criteria consistently in two pharmacy prior	SCFHP has revised a Pharmacy procedure PH.03.01 "Medi-Cal/HK Prior Authorization Procedure v5" to include processes to review formulary alternative drugs that require step therapy or prior authorization following a non-formulary drug request denial. SCFHP has updated the Off-Label Prior Authorization Request Criteria v3 to align for review consistency with California Code, Health and Safety Code 1367.21 sec 3(c).	• PH.03.01 "Medi-Cal HK Prior Authorization_ v6_draft".docx • Prior Authorization Criteria - Off-Label Criteria_v4.docx	July 12, 2019	**08/13/19** – The following documentation supports the MCP's efforts to correct this deficiency: - Updated P&P "PH.03.01 "Prior Authorization Process" (draft v.6) has been amended (Page 3) to include a section on clinical review. "A qualified medical director or Pharmacist will review PA against SCFHP criteria and use clinical judgment based on generally accepted drug compendia and professional practice guidelines to approve or deny the PA." Requesting providers will be required to submit supporting documentation when requesting a drug be prescribed for a use that is different from the use for which the

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authorization denials. Three root causes contributed to this issue. The Plan's clinician failed to conduct a PubMed online search to identify two published randomized controlled peer-reviewed journal studies that support the proposed use of the medication for the requested indication as safe and effective. Furthermore, the Plan's clinician failed to pre-approve formulary drug with prior authorization criteria when evaluating a request for a non-formulary drug of the same therapeutic drug class. In addition, the Plan's quality assurance process (or inter-rater reliability				drug has been approved. Responsibility has been placed on the requesting provider to submit supporting documentation from major peer-reviewed journals that present data supporting proposed off label use or uses as generally safe and effective. The review has the discretion to pre-authorize a formulary drug that requires prior authorization when a non-formulary drug is requested. Secondary Clinical Review is utilized when a decision cannot be made based on the information provided in a request due to questionable medical necessity or inappropriate use of drugs. Pharmacy Director or licensed healthcare professional will review monthly samples of denial prior authorization requests for appropriate language and rationale. - Updated P&P "Drug Prior Authorization Request Criteria (Off-

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(IRR) reviews) did not adequately address the inconsistencies identified in this audit. The Plan failed to apply medical necessity criteria consistently in pharmacy prior authorization decisions. This caused an unnecessary delay for the member to get medically necessary drug therapy.				Label)" (07/12/19), which has been amended to require the requesting provider to submit at least two published randomized controlled peer-reviewed medical studies that will support the proposed use of the drug for the documented diagnosis. **03/06/20** - The MCP submitted additional supporting documentation: the IRR cases, worksheet templates, and the answer key. The MCP conducted a Pharmacy department IRR verification study (12/30/19) to gauge the effectiveness of implemented procedures and demonstrate compliance. 2020 consecutive Medical audit did not reveal deficiencies in this area. Verification study included pharmacy prior authorizations requests, which were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to providers and members.

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				This finding is closed.
2. Case Management and Coordination of Care				
2.1.1 – Lack of Initial Health Assessment Completion by Primary Care Provider The Plan did not meet the contractual requirements of an IHA completion within 120 calendar days of a member's enrollment. The verification study showed that for six members there was no documentation showing that an IHA was completed. The Plan was not aware of this until Department of Health Care Services (DHCS) requested medical	SCFHP has updated a Quality Improvement procedure QI.10.02 to include additional IHA monitoring aspects. The Plan will initiate a Corrective Action Plan for when providers: • Fail two consecutive quarterly IHA audits • Fail to submit medical records for a quarterly IHA audit • Fail to document and/or submit documentation for member outreach attempts to schedule/reschedule an IHA appointment	• Policy QI.10.02 – "Initial Health Assessments (IHA) and Staying Healthy Assessment (SHA)" • IHA Corrective Action Plan Template	Beginning with Q2 2019 IHA audit	**08/13/19** – The following documentation supports the MCP's efforts to correct this finding: - Updated draft P&P "QI.10.02: Initial Health Assessments (IHA) and Staying Healthy Assessment (SHA)" includes reporting IHA percentage compliance to internal dashboard. Quarterly audits are conducted on each required element of an IHA, including the SHA. The Policy has been amended to include Corrective Action Plans for non-compliant providers who do not submit documented proof of unsuccessful attempts to schedule or reschedule an IHA appointment. (Section 8, 1(f), (h)). Additionally, providers who fail to meet required audit standards are educated on the requirements for completing an IHA and SHA and follow up is conducted, resulting in

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records for review.				potential corrective action. Furthermore, aggregate results are shared with the Quality Improvement Committee (QIC) quarterly. Oversight of IHA and SHA is monitored by the QIC and interventions taken as needed. (Section 8, 1(i) (j) - IHA Corrective Action Plan Template "Corrective Action Plan Notification" demonstrates the MCP's readiness to follow up on non-compliant providers, to ensure the providers follow the Plan's IHA procedures. **This finding is closed.**
2.2.1 – Lack of Primary Care Physician Participation The Plan does not have procedures in place to ensure PCP's participation and input in the development of members' care plans.	• SCFHP will be revising policy QI.13 to include specific requirements to notify PCP of active CM services. • SCFHP developed and implemented the direct CM phone line.		August 14, 2019 Q3 2019	**8/13/19** - The following documentation supports the MCP's efforts to correct this finding: - Drafts of provider engagement letters used to solicit PCP participation on the development of member's care plans. **12/3/19** - The following additional

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The Plan's Policy QI.13 and Plan's 2018 Complex Case Management Program Description did not indicate the role of PCP in the development of members' care plans.	• SCFHP has updated the provider correspondence with the direct CM phone line. • SCFHP will be revising the procedure QI13.05 updated to include the role and responsibility of the PCP on the interdisciplinary care team and ways the plan's Care Managers correspond with providers.	• Copy of existing Provider engagement letters	Q3 2019 August 14, 2019	documentation supports the MCP's efforts to correct this finding: - Policy QI.13 was modified to include the requirement to notify PCP of active CM services. (Page 1) - Policy QI.13.05 was revised to include the role and the responsibility of the PCP on the interdisciplinary care team (ICT) as well as communication with the ICT - Email communication with the MCP dated 12/3/19 confirmed that the direct CM phone line is operational. **This finding is closed.**
2.3.1 – Policy and Program Description do not Reflect APLs 15-025 and 18-006 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements The Plan was aware	SCFHP has updated the Quality Improvement policy QI.17 "Behavioral Health Care Coordination" to reflect the changes listed in APL 18-006 that state BHT services extend to members under the age of 21 years with or without an autism diagnosis. This policy was approved at the Quality	• Policy QI.17 Behavioral Health Care Coordination • QIC Agenda June 12, 2019	June 12, 2019	**6/5/20** - The following documentation supports the MCP's efforts to correct this finding: - Policy QI.17 was updated to list elements of EPSDT requirements for BHT present in APL 18-006 **12/22/20** - The following additional documentation supports the MCP's

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of the APL 18-006 requirements; however, the Plan did not update its policy for the BHT program to reflect the current APL guidelines. The Plan acknowledged that they are still working on finalizing the policy and the program.	Improvement Committee on June 12, 2019.			efforts to correct this finding: - Procedure QI.17 was updated to include the eleven behavioral treatment plan requirements and criteria changes listed in APL 19-014 which supersedes APL 18-006. **This finding is closed.**
2.4.1 – Lack of Oversight on Transportation Delegates The Plan's Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) delegates did not consistently provide members with transportation services in a timely manner. The verification study	SCFHP provides ongoing monitoring and oversight of the transportation providers through different channels listed below. Please see NEMT/NMT Narrative for details. • Grievance and Appeals review Committee • Quality Improvement Committee • Claims submission	• NEMT/NEMT Narrative • Q1 2019 GARC Slides • Q1 2019 QIC Slides • Procedure CS.14.01 v2 • Policy CP.07 • JOC Agendas with NMT/NEMT	• Daily, monthly, Quarterly & Ongoing • March 21, 2019 • March 28, 2019 • May 29, 2019	**8/13/19** - The following documentation supports the MCP's efforts to correct this finding: -A written response, "NEMT/NMT Transportation Oversight Narrative (-8/12/19)" that verifies all coordination of member transportation is performed by MCP staff. Several business units provide oversight of transportation providers to comply with all applicable state and federal laws and regulations, contractual requirements and other requirements set forth by DHCS guidance and dual plan letters.

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disclosed that members did not receive transportation services as scheduled in two cases. In addition, a review of two grievance cases indicated that members missed their appointments because drivers did not show up	• Call Center ride scheduling • Joint Operations Committee Meetings	providers		Claims (ongoing and monthly) which are processed within the MCP's operating system and reviewed through FWA process. Compliance (ongoing and monthly). The MCP's FWA vendor performs data mining and trend analysis to identify and investigate outliers and variations in performance (coding issues, fraud schemes, duplicate claims). Utilization Management (ongoing) monitors the prior authorization process for transportation in adherence with all applicable state and federal laws and regulations. Grievance and Appeals (ongoing and quarterly). Transportation grievances are monitored through the MCP's Grievance and Appeals Review Workshop and Quality Improvement Committee. Oversight (ongoing and bi-annually). Joint Operations Committee review utilization reports from transportation providers with the highest utilization.

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				Discussions include operations, contracts, compliance related topics. Issues involving transportation providers is discussed monthly in the Delegation Oversight Committee. MCP to audit high volume transportation providers for Medi-Cal line of business in 2020. Provider Network Management (ongoing) is also working with transportation providers to create a safety checklist to ensure proper procedures are followed and documented. - Joint Operation Committee agendas with multiple transportation providers serve as evidence the MCP and its providers are meeting to share information and discuss compliance related issues. - Policy CS.14.01 describes the MCP's reporting and monitoring of NMT requests. - Q1 2019 GARC slides demonstrate

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				the MCP monitors its grievances by categories including transportation. **6/9/20** - The following additional documentation supports the MCP's efforts to correct this finding: - Email communication from 6/5/20, The MCP is planning on auditing two of its high volume transportation providers in Q1 2021 with results available in Q2 2021. In the meantime the MCP will conduct internal monitoring through internal departments. **This finding is closed.**
2.5.1 Continuity of care during pregnancy The Plan did not comply with continuity of care requirements for the provision of covered services throughout the duration of three trimesters in cases of	SCFHP has updated the UM procedure HS.01.05 "Continuity of Care" in accordance to the continuity of care criteria of "continuation of care through the post-partum period for the second or third trimester of pregnancy" as stated in DPL 16-002.	• HS.01.05 "Continuity of Care" (updated)	August 5, 2019	**08/27/19** – The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "HS.01.05: Continuity of Care" (08/26/19) which has been revised to comply with continuation of care requirements which includes pregnancy for all three trimesters of pregnancy and immediate

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pregnancy				postpartum period (page 2 and 4). - Updated Provider Manual (08/26/19), which includes that MCP provides complete covered services for the duration of pregnancy and up to 36 months post-partum. Definition of pregnancy is added to Provider Manual stating that pregnancy is defined as three trimesters of pregnancy and immediate post-partum period to comply with continuity of care requirements (page 38). **This finding is closed.**
2.5.2 - Continuity of Care for members with pre-existing provider relationships The Plan's desktop resource for continuity of care screening includes the following: acute condition,	SCFHP has updated the UM procedure HS.01.05 "Continuity of Care" in accordance to the continuity of care criteria stated in health and safety code Section 1373.96 and APL 15-019 and APL 18-008 which states that all members with a preexisting provider relationship who make a	• HS.01.05 "Continuity of Care"	August 5, 2019	**08/13/19** – The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "HS.01.05: Continuity of Care" (08/05/19) which has been amended to include that members with pre-existing provider relationship must be given the option to

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serious and chronic condition, pregnancy and postpartum period, care of a newborn child between birth and age of 36 months, surgery or other authorized procedures and terminal illness. However, the Plan's desktop resource did not mention that members with pre-existing provider relationship could continue to see the current provider.	continuity of care request to an MCP must be given the option to continue treatment for up to 12 months with an out-of-network (or non-contracted) Medi-Cal provider.			continue treatment for up to 12 months with an out-of-network provider (page 1-2). **This finding is closed.**
4. Member Rights				
4.1.1 – Inclusion of a State Fair Hearing Option in Grievance Resolution Letter to Members The Plan included an option for members to request a State Fair Hearing. However, a State Fair Hearing	SCFHP has reviewed and revised our grievance notices to exclude the State Hearing rights. SCFHP removed the State Hearing language from the grievance resolution letters effective March 2019. The notices have since been reviewed and revised. The	1. 50266 Grievance Resolution Letter.zip 2. 50276 Grievance Acknowledgement Letter.zip	Short Term date: March 7, 2019	**08/12/19** – The following documentation supports the MCP's efforts to correct this finding: - Updated grievance resolution letter (March 2019) as evidence that the MCP has removed the State Fair Hearing language from their grievance resolution letters.

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may only be requested if the Plan's internal appeals process has been exhausted and a NAR is issued.	notices are pending the DHCS contract manager's review as of August 2019. Additionally, the Grievance & Appeals Department is recruiting a Quality Assurance Program Manager that will be responsible for reviewing notices prior to mailing to the member. The intent of the position is to ensure our members receive the appropriate resolution, including the appropriate rights.	3. Grievance and Appeals Quality Assurance Program Manager Job Description	Long-term date: September 1, 2019	- Grievance and Appeals Quality Assurance Program Manager Job Description (08/05/19) in which the MCP is recruiting for a new Grievance and Appeals supervisor. This position will conduct quality review of grievances and appeals to ensure they are categorized and processed in accordance with state and federal regulatory requirements. The Grievance & Appeals Quality Assurance Program Manager was hired on September 1, 2019. **03/03/20** – The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - Written statement from the MCP (03/03/20) explaining that G&A Management began weekly training sessions that went over making clarifying calls to obtain a clearer understanding of grievances, when needed, and grievance categorization and the importance of accurate categorization.

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				The G&A Program Manager began monitoring grievance resolution letters. The Program Manager pulls two cases from each of the G&A Coordinators, two of which are focused on the Cal MediConnect line of business, and reviews for accuracy and completeness of the resolution. Additionally, the QA Program Manager leads a monthly trend analysis with the G&A Coordinators. This helps them to better understand the issues that occur and helps them to brainstorm how to fully resolve issues in the future. - Grievance & Appeals Department Weekly PowerPoint Training slides (September 2019 - February 2020) and sign-in sheets as evidence that the MCP is providing to G&A staff a clearer understanding of grievances, when needed, and grievance categorization, and the importance of accurate categorization. **This finding is closed.**

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4.3.1 Privacy Information Reporting Requirements The Plan did not monitor and provide appropriate training to the compliance staff; as a result, staff misunderstood the PIR reporting timeline requirement of 72 hours.	SCFHP will provide a refresher training on procedure CP20.01 "Health Information Privacy" to the Plan's Compliance Department over the required timeframes to ensure a timely submission of the privacy incident reports.		Q4 2019	**05/06/20** - The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - PowerPoint training, "HIPAA Privacy and Security Overview" (Quarter 4, 2019) and sign-in sheets as evidence that the MCP's Compliance Department staff completed a refresher training on HIPAA Privacy and Security. In addition, the MCP's Compliance department had an informal training and discussion on the reporting requirements within procedure CP20.01 "Health Information Privacy" in one of the MCP's department meetings. - Spreadsheet Report, "SCFHP Disclosure Tracking Log Template" as evidence that the MCP is monitoring their privacy information reporting requirements by logging their PIR submissions to DHCS. The tracking log includes columns such as, "Date Reported To DHCS" (within 24 hours of incident notification),

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				"Date PIR Submitted to DHCS" (within 72 hours of incident notification), and "Date Complete Report Submitted to DHCS" (within 10 days of incident notification). **This finding is closed.**
5. Quality Management				
5.2.1 – Plan's Policies related to New Provider Training The Plan's Policies P025-05 and PS010-08 related to new provider training did not specifically state that new providers must complete the new provider training within 10 working days from the Contract effective date based on contract requirements. Therefore, eight of the new provider did not complete the training	SCFHP has developed a new policy PN.04 v1 "Provider Orientation and Education" and procedure PN.04.01 v1 "New Provider Orientation" attached, to replace previous policies which includes clarification that the initial provider orientation is to occur within 10 business days after contract effective date, as well as the process for overseeing SCFHP performance and delegate performance related to this task.	• Policy PN.01 v1 • Procedure PN.04.01 v1	August 5,2019	09/24/19 – The following documentation supports the MCP's efforts to correct this deficiency: - Newly developed P&P, "PN.04.01 V3: New Provider Training" (drafted 09/24/19) (replaces P&P, PS025-025) which states, "The Provider Network Management Department conducts the new provider training within ten (10) business days of the effective date of the contract". **This finding is closed.**

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within 10 working days.				
5.2.2 – Plan's Oversight for the New Provider Training The Plan did not have an adequate quality assurance process and proper oversight of its delegated entities to ensure timely new provider training. In addition, the Plan failed to address the inadequate maintenance of records regarding new provider training. This may result in providers being unaware of Medi-Cal covered services, which may delay the	SCFHP has developed a new policy PN.04 v1 "Provider Orientation and Education" and procedure PN.04.01 v1 "New Provider Orientation" regarding new provider orientations and delegate responsibilities and oversight process.	• Policy PN.01 v1 • Procedure PN.04.01 v1	August 5, 2019	**09/06/19** – The following documentation supports the MCP's efforts to correct this deficiency: - Amended P&P, "PN.04.V3:New Provider Training" (09/06/19) which has been amended to include a section on the MCP's process for providing and/or ensuring that new providers receive training within (10) business days after the named provider's effective date. - Attestation forms, "New Provider Orientation" (04/13/18, 06/11/18, and 09/13/18) that the delegated entities are sending these forms to the MCP as evidence that the new providers are receiving the orientation training. - Audit Tool, "2019 Annual Oversight Audit" (2019) as evidence that the MCP is auditing the delegates for

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delivery of contractually required services to members.				having policies and procedures describing the process for providing training to PCPs and SPECs serving Medi-Cal beneficiaries and if delegates are maintaining a log of completed provider trainings, training log must contain at the minimum: - Providers Name - Providers Title - License number - Effective date of contract - Date of training In addition, MCP ensures delegates has a process to ensure that providers are trained within 10 working days from their enrollment or contract effective date with the delegated entity. - Tracking Log, "Premier Care of Northern California New Providers 2018 Tracking Log" (2018) as evidence that the delegated entities are monitoring to consistently provide training to new providers within 10 working days.

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				06/16/20 – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: - An email 6/16/20 which includes a description of the MCP's process for performing annual audits. The MCP delegated entities submit quarterly New Provider Orientation logs that are reviewed by our Provider Network Management (PNM) Department. In addition, the Plan conducts annual audits of our delegates and provider training is one of them audited areas. **08/27/20** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: - Audit Report, "2019 Annual Audit of Premier Care of Northern California/Conifer Health MSO (PCNC) Medi-Cal and Health Kids" (Audit Period, 01/01/18 to 12/31/18) as evidence the MCP is conducting

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				yearly delegation oversight to ensure timely provider training. **This finding is closed.**

Submitted by: Christine M. Tomcala [Signature on File] **Date:** August 12, 2019
Title: Chief Executive Officer