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

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

July 14, 2020

Valerie Martinolich, Compliance Officer
UnitedHealthcare Community Plan of California, Inc.
8880 Cal Center Drive, Suite 300
Sacramento, CA 95826

RE: Department of Health Care Services Medical Audit

Dear Ms. Martinolich:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of UnitedHealthcare Community Plan of California, Inc., a Managed Care Plan (MCP), from May 28, 2019 through June 7, 2019. The survey covered the period of April 1, 2018 through April 30, 2019.

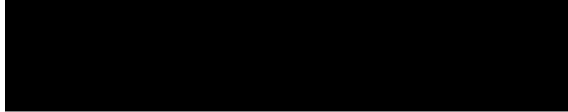
On May 29, 2020, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on October 18, 2019.

All items have been reviewed and DHCS accepts the MCP's submitted CAP. The CAP is hereby closed. Full implementation of the CAP will be monitored 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: Priscilla Peco, 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: United Healthcare Community Plan of California, Inc. **Review Period: 04/01/2018 – 04/30/2019**

Audit Type: Medical Audit and State Supported Services **Onsite Review: 05/28/2019 – 06/07/2019**

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				
1.2.1: The Plan did not ensure that all California Children's Services (CCS) members receive medically necessary services. UM and Case Management (CM) did not coordinate CCS member services.	Work flow documents for the Prior Authorization Team were updated: The Case Management team will be notified of any prior authorization denial promptly. Case Management policy was updated to include more monitoring details and ensuring coordination of services between the Plan, CCS and the CCS providers. Prior Authorization and Case Management staff was trained on the new tools and process. All denials were audited for verification of new process in place for 30 days. Process check is included in the ongoing Prior Authorization staff performance audits.	CA OPS CCS 01 Continuity and Coordination of Care CCS Job aid for PA CCS denials 062109 Staff Training for Finding 1.2.1 CCSCOC audit tool 112019	July 5, 2019	**11/20/19 –** The following documentation supports the MCP's efforts to correct this finding: - Job aid, "Coordination of care for denied services for California Children's Services responsibility" as evidence that staff receive guidance on the process to coordinate requests for CCS covered services that are denied for payment by the Plan and should be covered by the CCS program. The purpose of the job aid is to direct staff on how case management will coordinate care to support the member when a CCS covered service is denied by the Plan. - Screenshot of an email (09/24/19) between Prior Authorization and Case Management staff that includes a description that staff

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				reviewed the job aid and updated process. **12/10/19** – The following additional documentation submitted supports the MCP's efforts to correct this finding: - Updated P&P, "CA OPS CCS 01: California Children's Services (CCS) members Continuity and Coordination of Care" (07/01/19) which has been amended to address coordination between UM and CM department regarding prior authorization requests for potential CCS covered and non-covered services. IF CCS denied a requested service, MCP will cover the service if it is a benefit or medically appropriate. Updated P&P also includes monitoring and oversight measures through monthly audits. Reports for denied prior authorization requests related to CCS will be

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				obtained every month in which each case will be audited using the CCS COC audit tool. - Sample audit report, “CCS COC Audit Tool” (12/2019) as evidence that the MCP is conducting reviews of prior authorization requests denials. The audit tool includes components of ensuring that coordination of care between primary care providers, CCS, and Case Management team. Audit results reveal that MCP is implementing their P&P and conducting proper monitoring and oversight measures. **01/17/20** – The following additional documentation submitted supports the MCP’s subsequent efforts to correct this finding: - MCP’s written narrative as evidence that MCP which includes screenshots of a CCS prior authorization case as an

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				example of how CCS, UM, and CM department coordinate CCS services. The narrative also states, “If a missed case were to be found; immediate action would be taken to outreach to member, provider, and CCS if needed. There would also be remediation or education to staff involved.” **This finding is closed.**

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1.3.1: The Plan used non-physicians to make the final decision on the resolution of expedited appeals. Final decisions of appeals related to denial involving clinical issues must be determined by a person having clinical expertise in treating the member's condition or disease.	United Clinical Services (UCS) implemented a process to ensure that physicians make the determination to downgrade the review priority of an expedited appeal request. UCS Clinical Appeals Nurses were instructed to route expedited appeal cases with potential downgrades to a Medical Director (MD or DO) for handling. The UCS Clinical Appeals Medical Directors were advised that they must make the determination on whether to downgrade the review priority of an expedited appeal request. The job aid used by the Clinical Appeals teams was updated to capture the process. A 90-day monitoring period is currently underway to confirm downgrades are only being made by physicians. Data is pulled and reviewed every 30 days. During the first 30 days of the monitoring period no	1.3.1 C&S CA_iCAR Expedited Appeals Downgrade Monitoring Job Aide Screenshot	By July 30, 2019, UCS Clinical Appeals Nurses and Medical Directors had been advised of the regulatory requirement and the new process. On August 8, 2019, updates to the job aid were completed. The 90 day monitoring period concluded on October 27, 2019.	**11/20/19 –** The following documentation supports the MCP's efforts to correct this finding: - Job aid, "Coordination of care for denied services for California Children's Services responsibility" as evidence that staff receive guidance on the process to coordinate requests for CCS covered services that are denied for payment by the Plan and should be covered by the CCS program. The purpose of the job aid is to direct staff on how case management will coordinate care to support the member when a CCS covered service is denied by the Plan. - Screenshot of an email (09/24/19) between Prior Authorization and Case Management staff that includes a description that staff reviewed the job aid and updated process.

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	downgrades occurred.			**12/10/19** – The following additional documentation submitted supports the MCP's efforts to correct this finding: - Updated P&P, "CA OPS CCS 01: California Children's Services (CCS) members Continuity and Coordination of Care" (07/01/19) which has been amended to address coordination between UM and CM department regarding prior authorization requests for potential CCS covered and non-covered services. IF CCS denied a requested service, MCP will cover the service if it is a benefit or medically appropriate. Updated P&P also includes monitoring and oversight measures through monthly audits. Reports for denied prior authorization requests related to CCS will be obtained every month in which each case will be audited

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				using the CCS COC audit tool. - Sample audit report, "CCS COC Audit Tool" (12/2019) as evidence that the MCP is conducting reviews of prior authorization requests denials. The audit tool includes components of ensuring that coordination of care between primary care providers, CCS, and Case Management team. Audit results reveal that MCP is implementing their P&P and conducting proper monitoring and oversight measures. **01/17/20** – The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - MCP's written narrative as evidence that MCP which includes screenshots of a CCS prior authorization case as an example of how CCS, UM, and CM department coordinate

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				CCS services. The narrative also states, “If a missed case were to be found; immediate action would be taken to outreach to member, provider, and CCS if needed. There would also be remediation or education to staff involved.” **This finding is closed.**

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3. Access and Availability of Care				
3.3.1 The Plan does not have policies and procedures to ensure non-contracting Emergency Room department services are at a minimum reimbursed at the lowest level emergency department evaluation and management Physician's Current Procedural Terminology (CPT Code). The Plan's procedure was to deny claims submitted without sufficient documentation instead of paying at the lowest CPT code for the services rendered.	**Short Term Solution:** All claims for ER place of service are manually routed and the plan has verified that lines are not being denied for medical records. There is a process to ensure all ER claims are processed and appropriate reimbursement is received. **Long term Solution:** Worked with the claims adjudication team to implement an automatic filter to allow ER claims to be automatically processed without medical record denials. A report is pulled and monitored daily to ensure that no ER claims are being denied for medical records. **For Facility Claims:** The system edit used for facility claims has been turned off	Prospective Review CnS CA ED Claims SOP Report Template	July 17, 2019 July 22, 2019 Ongoing August 2, 2019	**11/21/19** - The following documentation supports the MCP's efforts to correct this finding: - CnS Prospective Review of CA Emergency Department Claims Process Job Aid (effective date 11/8/19) describes the filter that allows ER claims to pass through without being held for additional records request. - Report Template used to ensure that ER claims are not being denied for medical records. **2/25/20** - The following additional documentation supports the MCP's efforts to correct this finding: - ER Claim File July 2019 – December 2019 serves as evidence the MCP is actively monitoring ER claims. **This finding is closed.**

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	therefore no ER facility claims deny for medical records.			
3.3.2 Members have the right to access family planning services through any provider without prior authorization. The Plan required prior authorization for family planning claims.	**Short Term Solution:** All denied claims were promptly corrected upon discovering the error and corrected the issue with provider set up tied to the clinic noted. **Long Term Solution:** All services related to family planning were reviewed and the claim process was expanded with configuration based on an updated list of ICD10 and CPT codes not to require prior authorization. This will address any gaps included in the findings. A claim monitoring process was implemented to initially look at 100% of Sensitive Service claims post adjustment. Once	Expanded Configuration list of ICD-10 and CPT Codes Not Requiring Prior Authorization CA_Abortion and Family Planning Configuration Overview 10_01_19 ER_Fam_Abor_ Review 9_5_19_er_fam_ abor_review Report Template	Short term: April 22, 2019 Long term: August 15, 2019	**11/21/19** - The following documentation supports the MCP's efforts to correct this finding: - Expanded Configuration list of ICD-10 and CPT Codes Not Requiring Prior Authorization details Family Planning and State Supported Services codes that do not require prior authorization. - CA Abortion and Family Planning Overview list abortion and family planning codes and demonstrated that the system configuration does not require prior authorization - 9/5/19 and 10/1/19 Family Planning and Abortion Review serve as evidence of monitoring of family planning and abortion claims.

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	consistent results were validated, the plan resumed monthly claim monitoring.			**4/1/20** - The following additional documentation supports the MCP's efforts to correct this finding: - Example of Claims Monitoring report. These claims reports are pulled on a monthly basis with all family planning claims processed within the previous month. All denials are reviewed to ensure the denial is correct. Any denial for no authorization would be immediately escalated to leadership for correction and analysis. **This finding is closed.**
4. Member Rights				
4.1.1 Non-physicians reviewed and resolved Quality of Care (QOC) grievances. The Contract requires all QOC grievances to be referred to the Plan's Medical Director.	The Plan has had an opportunity to analyze the reviewers' comments, review the cases and internal process and policies. The Plan's policies and current process require Medical Director review of all QOC concerns, including those received through the grievance process. The Plan	4.1.1 QOC Job Aid - 120 CA Community and State Grv Training	July 31, 2019	**11/20/19** - The following documentation supports the MCP's efforts to correct this finding: - PowerPoint Training, "Grievance Training CA" (03/25/19) as evidence that MCP internal Appeals and Grievances staff received training for the identity of QOC concerns. Non-clinical staff also received training on

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	identified that certain grievances were not identified as potential QOC and therefore were not referred for QOC investigation and Medical Director determination. Additionally, the Plan identified that non-clinical staff were noted to reject referrals to the QOC team. As Corrective Action and internal process improvement the following steps have occurred: • Training to internal Appeals and Grievances staff to identify potential QOC concerns, using key words and key concepts of the definition of quality of care concern was completed on March 25, 2019. • QOC non-clinical staff were trained to accept all referrals for QOC investigation, or if criteria are not met for referral, to refer those cases for clinical review by a Medical Director. Staff training			referring QOC for investigation (04/30/19). **04/10/20** - The following additional documentation supports the MCP's efforts to correct this finding: - Updated P&P, "CAOPS126: Member Appeal and Grievance Policy and Procedure" (02/13/20) which has been amended to include Medical Director review of all Quality of Care concerns, including those received through the grievance process. The P&P states, a grievance that involves clinical issues, and if medical quality of care issues are identified, shall immediately submitted to the medical director for action (page 16). - Sample E-Mails, "CA Weekly Grievance Log E-Mails" (January – April 2020) between the Chief Medical Officer (CMO) and the Appeal and Grievance Team as evidence that the CMO performs a weekly review of Non-Exempt

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	was completed on April 30, 2019, with ongoing monthly training initiated beginning on June 6, 2019. A revised job aid was completed on July 31, 2019. • Beginning on March 8, 2019, the Chief Medical Officer (CMO) has initiated weekly review and oversight of all new grievance cases to provide an additional review of all cases for potential QOC concern and referral. • The CMO has initiated weekly review and oversight of all exempt grievance cases to provide an additional review of all exempt grievance cases for potential QOC concern and referral that may have not been identified and referred by member services staff.			(standard) grievances. The CMO communicates recommendations or concurrence, if no Quality of Care concerns exist. - Sample Spreadsheet, “March 2020 Exempt Grievances - Submission” as evidence that the CMO is reviewing exempt grievances on a bi-weekly basis with the MCP’s call center lead staff. In March 2020, these reviews were enhanced by capturing written minutes and comments during the review hour. **This finding is closed.**

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4.1.2 The Plan did not ensure adequate consideration and resolution before closing the grievances and mailing resolution letters to members. The Plan mailed resolution letters to members while still investigating the grievance.	Appeals & Grievance (A&G) staff has been trained to ensure all matters of a grievance are investigated, resolved and all action items taken to resolve the grievance are clearly communicated in the member resolution letter. The following Standard Operating Procedures have been updated to ensure grievances are fully investigated. The grievance issues must be identified and fully resolved prior to closing the grievances and mailing a resolution letter to the member. **The Client letter Standard Operating Procedure** refer to the Letter Quality Checklist section, Letter content states "*All issues in the appeal or grievance must be addressed (i.e., all services, claims, dates of service, etc.)" as well as* directs the analyst to National Committee for Quality Assurance (NCQA) Letter Job	Grv Training Client Letter SOP	CA Grievance Training- completed March 25, 2019 Client Letter SOP updated June 3, 2020	**11/20/19** - The following documentation supports the MCP's efforts to correct this finding: - PowerPoint training, "CA Grievance Training" (03/25/19) as evidence that Appeals & Grievance staff received training to ensure all matters of a grievance are investigated, resolved and all action items taken to resolve the grievance are clearly communicated in the member resolution letter. The PowerPoint training address that all information related to the grievance is reviewed and considered before a response is provided. Reviewed information includes, but is not limited to information submitted by the enrollee or the enrollee's authorized representative, claims, chart notes and previously reviewed documentation (slide 3). - Updated Desktop Procedure, "Client Letter SOP" (10/22/19) which has been amended to include a section on letter content. The updated

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	Aid prior to case closure to ensure the *a complete response of all issues raise are addressed".* **The National Committee for Quality Assurance (NCQA)** Checklist Job aide states: *"Have I Developed a complete response that addresses the issues raised in the appeal?"* **The California Quality of Care/Quality of Service Standard Operating Procedure (SOP**) under the Resolving Analyst Section step 11 directs the analyst to the Client letter Standard Operating Procedure and National Committee for Quality Assurance (NCQA) Letter checklist prior to case closure to ensure all issues are addressed. The SOP states "*ensure all issues are resolved. Resolved means that the grievance has reached a final conclusion with respect to the enrollee's submitted*	NCQA Checklist Job Aid The California Quality of Care Quality of Service Standard Operating Procedure (SOP) CA Clinical Member SOP	NCQA checklist updated June 14, 2019 CA QOC/QOS SOP updated October 16, 2019 CA Clinical Member NCQA updated June 3,	desktop procedure states that all issues in the appeal or grievance must be addressed (i.e., all services, claims, dates of service, etc.). This may be done in more than one case or letter as needed, as long as all issues are ultimately responded to in some way. Member Appeal Uphold/Partial Uphold letters for most states must comply with NCQA standards. Refer to the NCQA Job Aid job aid (page 13). - Updated, "NCQA Letter Checklist" (04/22/19) to be used by Appeals & Grievance Staff in checking the quality of the resolution letter before it is sent to print. The letter checklist asks the Appeals & Grievance Staff if they have developed a complete response that addresses the issues raised in the appeal. - Updated, "California Quality of Care/Quality of Service Standard Operating Procedure (SOP)" (10/16/19) and "California Admin Member Standard Operating

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	grievance". **The California Clinical Member Standard Operating Procedure (CA Clinical Member SOP)** under the Overturn step 4 and Uphold section directs the analyst to Client letter Standard Operating Procedure and National Committee for Quality Assurance Letter checklist prior to case closure. **The California Admin Member Standard Operating Procedure (CA Admin Member SOP**) under section Billing issues step 9, state to e*nsure all issues are resolved. Resolved means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance. Note: Refer to the client Letter SOP and the NCQA Checklist job aid.* *Overturn section step 4, states Refer to the Client Letter SOP*	CA Admin Member SOP CA Member Audit	2019 CA Admin Member SOP updated June 3, 2019 and Issue resolution updated October 15, 2019	Procedure (CA Admin Member SOP)" (10/15/19) which instructs the Appeals & Grievance Staff to ensure all issues are resolved. Resolved means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance. - Updated, "California Member Audit Tool," (09/03/19) as evidence that the MCP is monitoring to ensure that all member issues were addressed in the grievance resolution letter. The audit tool includes a column to address if, "All Member Issues Addressed." **This finding is closed.**

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	and Uphold section notes Refer to the Client letter SOP and NCQA Checklist job aid. **The California Member audit tool (CA Member Audit Tool Final**) The California Member Audit Tool has been enhanced to validate whether the grievance case is completely resolved and that the case letter includes a comprehensive clear and concise response to address all concerns and action items completed. column 'AF' ask *if all issues are addressed* The **California National Medicaid Member Appeal and Grievance Policy** page 18 instructs the resolving analyst must; *When required, written grievance decisions are issued within applicable regulatory timeframe requirements, and*	Tool_FINAL California National Medicaid Member Appeal and Grievance Policy	September 3, 2019 July 1, 2017	

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	must include the following elements, if applicable: • The letter is addressed to the grieving party, and where applicable, the provider or facility. • The specific reason(s) for the decision, in easily understandable language. • The right of a member to appeal a grievance decision • A clear and concise explanation of the disposition. APL 17-006 *42 CFR 438.408 (d), 438.410, and NCQA RR2*			
4.3.1 The Plan is required to notify DHCS immediately upon the discovery of a breach of unsecured Protected Health Information (PHI) and within 24 hours of the discovery of any suspected security incident, intrusion or	*Upon review, the Plan identified the correct contract language in the attached HIPAA POLICY on page 8, under provision H. To address the DHCS recommendation, the Plan's Privacy Office sent an instructional email to its staff informing them of the correct way to begin the reporting timeline for privacy incidents. A*	United_HIPAA Policy rvsd 07.18.19 Email Notifying Privacy Office of The Correct Receipt Date of Privacy Incidents	July 18, 2019	**11/25/19** – The following documentation supports the MCP's efforts to correct this deficiency: -The Plan did not have any incidents to report during the audit period. The audit team did not observe any issues with the MCP's incident detection system. - Revised P&P, "CA OPS 128"

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unauthorized access, use or disclosure of PHI or Personal Information (PI). However, the Plan's timeline to submit reports to DHCS begins after its national privacy office receives and reviews an incident. This deviation delays reporting of potential Health Insurance Portability and Accountability Act (HIPAA) · breaches to DHCS.	*copy of the email is attached as* "Email Notifying Privacy Office of The Correct Receipt Date of Privacy Incidents."			(11/21/19) which addresses the MCP will notify DHCS immediately by telephone call, email or fax upon the discovery of breach of security or PHI in computerized form or within 24 hours by e-mail or fax of any suspected security incident, as well as, interim and final reporting requirements. Notification will be provided to the DHCS Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer. **This finding is closed.**
4.3.2 The Plan's policies and procedures do not contain information related to submitting a completed Privacy Incident Report (PIR) to DHCS within ten working days of the	The Plan updated the HIPAA POLICY attached in redline format, to include the language: "provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security	United_HIPAA Policy rvsd 07.18.19 Email Notifying Privacy Office of The Correct Receipt Date of Privacy Incidents	July 18, 2019	**11/25/19** – The following documentation supports the MCP's efforts to correct this deficiency: - Updated P&P, "CA OPS 128" (11/21/19) which has been amended to address that the Plan will provide a complete report of the investigation to the DHCS Program Contract

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discovery of a breach or unauthorized use of PHI.	Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure".			Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of discovery of the breach or unauthorized us or disclosure. **This finding is closed.**
5. Quality Management				
5.2.1 The Plan did not ensure that network providers completed the new provider training within ten working days of being added to their Medi-Cal Managed Care Network. The Contract states that the Plan must ensure that network providers receive training related to the Medi-Cal program within ten working days of being placed in the Plan's active provider network.	**Medical Providers:** In an effort to ensure timely provider education, the following process has been established: • Provider advocates analyze the new provider load report to identify newly contracted providers. • Newly contracted providers receive a welcome email upon being identify as a new provider. The email outlines resources and tools that are available prior to the initial orientation. Resources and tools provided in the email include introduction to their	Medical: CS New Provider Process CA OPS304 Provider Advocate Welcome Notice Intro to UHC Community Plan_PDF	Medical: January 1, 2020	**11/20/19-** The following documentation supports the MCP's efforts to correct this finding: - Updated P & P, CA OPS 304: Provider Training and Outreach Plan which requires new provide orientation training within 10 business days of being placed on active status. MCP training process includes daily monitoring of requests for newly contracted provider education, a new provider load report is reviewed weekly. Upon identifying a new provider, a welcome email is sent to each new provider with an outline of

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	Advocate, How to connect to provider self-service tools, and information on required trainings. • A policy and procedure for Provider Education and Training of Medi-Cal providers has been developed for the provider advocates. • If a provider advocate is unable to complete new provider education within 10 business days with a specific provider, that provider will be suppressed from the network until education is completed or provider contract status is changed • Reports from new provider education are run monthly from the Impact system by Provider Relations Management and reviewed during staff meetings, and reports are ran quarterly and shared during plan meetings. **Behavioral Health Providers:**	Behavioral Health: P&P: Medi-Cal Provider	Behavioral Health: October 4, 2019	the upcoming process to onboard the provider to the network and necessary completed documentation to achieve this. If training is not completed within the required timeframe, the provider is suppressed from the network until education can be completed. - P&P, Provider Education and Training (QIC Approved/December 2019) describes the deliver and monitoring of required provider training and education for newly added providers. Policy includes notification and attestation requirements. Provider Relations staff uses reporting through Salesforce to monitor completion of Medi-Cal training. **02/03/20 -** The following additional documentation submitted supports

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	A Medi-Cal specific letter for newly credentialed providers has been implemented, including a link to Provider Express and instructions to complete Medi-Cal provider training within ten days of acceptance to the network. • CA Medi-Cal BH Welcome Letter has been implemented as of September 9, 2019 • CA Medi-Cal ABA Welcome Letter has been implemented as of September 30, 2019 • Informal training has been conducted with Credentialing staff as of October 4, 2019 • Automation of the Welcome Letter has been implemented as of October 4, 2019 An attestation, requiring providers to confirm completion of Medi-Cal Provider Training within ten days of acceptance to the network has been implemented as of May 31, 2019	Education and Training CA Medi-Cal ABA Welcome Letter CA Medi-Cal BH Welcome Letter		the MCP's efforts to correct this deficiency: - Sample reports, attestations, "Medical Provider Rosters, Narrative and Training Attestations as evidence that newly contracted staff members are receiving necessary documentation for new providers. - An Email (01/27/2020) which includes a description of the MCP's January 2020 audit findings and how their tracking process has been updated for better monitoring purposes to ensure the 10-day training period is met. **This finding is closed**

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	• Automation of the attestation has been implemented as of September 30, 2019 A Policy and Procedure for Provider Education and Training of Medi-Cal providers has been developed for the Provider Network team. • Provider network staff has been informally educated on the Provider Education and Training process as of October 3, 2019 • The Medi-Cal (Medicaid) Provider Education and Training Policy and Procedure has been approved by the P&P Committee as of October 3, 2019			
6. Administrative and Organizational Capacity				
6.2.1 The Plan is out of compliance with the Contract for timely reporting of Fraud, Waste, and Abuse (FWA) incidents. The	The Plan has drafted the attached draft policy California Fraud, Waste and Abuse Reporting, citing the contractual language, to clearly outline the process and timelines for	California Fraud, Waste and Abuse Reporting draft policy FWA Tracking		**11/20/19** – The MCP submitted following documentation to support its effort to correct this deficiency: - P&P CA OPS 127: "California Fraud Waste and Abuse Reporting",

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Plan does not have a written policy and procedure for timely reporting of FWA incidents to DHCS.	reporting Fraud, Waste or Abuse to the DHCS. A copy of the required MC609 form is attached to the policy. In order to ensure timely submission, the Plan has implemented the attached FWA Tracking Log that will be used to track all reportable Fraud, Waste or Abuse cases.	Log Template MC609		Section V., was updated (11/01/19), to reflect contractual requirements as it states in Contract A03, Exhibit E(2)(25)(B)(7). Furthermore, above-mentioned P&P clarifies the use of DHCS form "MC609" - "FWA Tracking Log Template", monitoring tool as evidence of established procedures for timely reporting of FWA incidents to DHCS. **05/29/20** - The MCP's written response confirmed one suspected incident of FWA in 2019. The MCP demonstrated timely reporting and the use of the proper form. (MC 609 was used to report the allegation.) **This finding is closed.**
6.2.2 The Plan did not report any cases of suspected or potential FWA incidents. A review was performed on the Plan's policies and procedures for	The Plan has drafted the attached draft policy California Fraud, Waste and Abuse Reporting, citing the contractual language, to clearly outline the process and timelines for reporting Fraud, Waste or	California Fraud, Waste and Abuse Reporting draft policy FWA Tracking Log Template		**11/20/19** – The MCP submitted following documentation to support its effort to correct this deficiency: - P&P CA OPS 127: "California Fraud Waste and Abuse Reporting", Section V., was updated (11/01/19),

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Contract compliance with Fraud and Abuse incident reporting requirements. The Plan did not follow the Contract, which requires them to promptly report to DHCS any potential FWA.	Abuse to the DHCS. A copy of the required MC609 form is attached to the policy. In order to ensure timely submission, the Plan has implemented the attached FWA Tracking Log that will be used to track all reportable Fraud, Waste or Abuse cases.	MC609		to reflect contractual requirements as it states in Contract A03, Exhibit E(2)(25)(B)(7). Furthermore, above-mentioned P&P clarifies the use of DHCS form "MC609" - "FWA Tracking Log Template", monitoring tool as evidence of established procedures for timely reporting of FWA incidents to DHCS. **05/29/20** - The MCP's written response confirmed one suspected incident of FWA in 2019. The MCP demonstrated timely reporting and the use of the proper form. (MC 609 was used to report the allegation.) **This finding is closed.**
State Supported Services				
SSS.1: The Plan denied payment of abortion claims for lack of prior authorization for services performed by out-of-network	**Short Term Solution:** All denied claims were promptly corrected upon discovering the error and corrected the issue with provider set up tied to the clinic noted.	Criteria Used for the Claim Holds Implemented CA_Abortion and Family Planning Configuration	Short term: April 22, 2019 Long term: August 15, 2019	**11/20/19**- The following documentation supports the MCP's efforts to correct this finding: - Sample reports - SSS and Family Planning overview outlines the MCPs recent

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providers. The verification study shows that two of ten claims were either partially or fully denied for prior authorization. The Plan's policy, CA OPS 030 Access to Services with Special Arrangements states, that Medi-Cal members have access to pregnancy termination services without prior authorization for outpatient services from any provider, including out-of-network providers. The Plan is not following their policies and procedures by denying family planning claims.	**Long Term Solution:** All services related to family planning were reviewed and the claim process was expanded with configuration based on an updated list of ICD10 and CPT codes not to require prior authorization. This will address any gaps included in the findings. A claim monitoring process was implemented to initially look at 100% of Sensitive Service claims post adjustment. Once consistent results were validated, the plan resumed monthly claim monitoring.	Overview 10_01_19 ER_Fam_Abor_ Review 9_5_19_er_fam_ abor_review Report Template		denied claims that were corrected and reimbursed. This brought to light a necessary configuration update to be made with the system to eliminate future denials, thereby allowing any abortion claims processed in or out of network to be adjudicated properly. **12/23/19**-The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - An email (12/23/2019) that confirms system configuration updates were made to the MCP's claims processing system. Claims billed with abortion-related procedure codes are no longer subject to any authorization codes/restrictions. Once system configuration was completed, MCP instituted a claims monitoring system

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				(noted above) that reviewed/ensured all claims were paid and did not require prior authorization. MCP continues to monitor monthly to ensure all abortion related claims are properly adjudicated. **This finding is closed**

Submitted by: Original Signed by Kevin Kandalaft

Date: November 20, 2019

Title: Chief Executive Officer