ATTACHMENT A
Corrective Action Plan Response Form

Plan: AIDS Healthcare Foundation **Review Period: 1/1/2019-12/31/2019**

Audit Type: Medical Audit and State Supported Services **Onsite Review: 2/4/2020 – 2/13/2020**

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

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. For deficiencies that require short-term corrective action, implementation should be completed within 30 calendar days. For deficiencies that require long-term corrective action or a period longer than 30 calendar days for implementation, the MCP must demonstrate it has taken remedial action and is making progress toward achieving an acceptable level of compliance. The MCP will be required to include the date when full compliance is expected to be achieved. **Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval in accordance with existing requirements.**

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

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
1. Utilization Management				
1.1.1 Finding - Integrating Reports of UM Activities Into the QIS: DHCS auditor reviewed the QMC meeting minutes and found that the minutes did	**1.1.1** Policy and Procedure UM 22.1 PHC-CA Authorization Referral Process was updated to include specific language that Utilization Management ("UM")	**1.1.1** 1. Policy and Procedure UM 22.1 PHC-CA Authorization Referral Process	**1.1.1** 6/8/2020	**08/03/20** - The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "CM 22: PHC-CA Authorization Referral Process" (08/03/20) which has been

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
not indicate the prior authorization break down and analysis of the types of appeals, denials, deferrals, and modifications. The Plan did not fully demonstrate integration of UM activities into the QIS for continuous improvement of the UM program and processes. During the interview, DHCS auditor discussed the QMC meeting minutes with the Plan staff. The Plan acknowledged the number and types of appeals, denials, deferrals, and modifications were not included in the QMC meeting minutes. The Plan did not fully implement policy UM 23.2 to present the required information to the QMC. As a result, the	will submit reports of UM activities to include breakdown and analysis reports on the number and types of appeals, denials, deferrals, and modifications for the appropriate QIS to be reviewed on a quarterly basis (see Page 4). Additionally, QMC has added these reports as a standing report for future QMC Meetings.	2. 09.08.2020 QMC Agenda		amended to include that the Utilization Management will submit reports to the Quality Management Committee regarding UM activities to include breakdown and analysis reports on the number and types of appeals, denials, deferrals, and modifications for the appropriate QIS to be reviewed on a quarterly basis. - Meeting Agenda, “Quality Management Committee Meeting” (September 2020) which now includes “Utilization Management: Appeals, Denials, Deferrals, and Modifications Report” as a standing report agenda item for future Quality Management Committee Meetings. **09/16/20** - The following additional documentation supports the MCP’s efforts to correct this finding: - Meeting Minutes, “Quality Management Committee Meeting” (09/14/20) which includes discussion regarding breakdown and analysis reports on the number and types of appeals, denials,

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
Plan may miss opportunities for improvement of their UM program. **<u>Recommendation:</u>** Revise and implement policy to ensure integration of UM activities to include breakdown and analysis reports on the number and types of appeals, denials, deferrals, and modifications for the appropriate QIS. Ensure the documentation of the integration in QMC for continuous improvement.				deferrals, and modifications. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
1.2.1 Finding - Non-Knox-Keene "Your Rights" Notice: The Plan became a Knox-Keene plan on 7/1/2019. As such, the Plan shall use the "Your Rights" attachment for Knox-Keene licensed plans on and after 7/1/2019. Plan policy PH.10, *Coverage Determinations & Redeterminations for Drugs and Therapeutic Devices* (eff October 2018), did not address the need to use the "Your Rights" attachment for Knox-Keene licensed plans. Two causes led to this finding. First, the Plan did not revise its pharmacy prior authorization policy to send members and prescribers the Knox-Keene "Your Rights" notice on and after 7/1/2019. Additionally, the Plan did not perform	**1.2.1** Letter templates in MedResponse Prior Authorization system were updated to include the correct Knox-Keene "Your Rights" attachment. Policy and Procedure PH 70.0 PHC-CA Prior Authorization Policy includes specific language to address inclusion of Knox-Keene "Your Rights" attachment to inform beneficiaries of appeal rights (Procedure Section 5d).	**1.2.1** 1. Policy and Procedure PH 70.0 PHC-CA Prior Authorization Policy 2. PHC NOA Letter Template	**1.2.1** 2/23/2020	**08/03/20** – The following documentation supports the MCP's efforts to correct this deficiency: - P&P, "PH 70-CA: Prior Authorization Policy" (07/20/20) (which supersedes Policy PH 10) has been revised to incorporate, adverse benefit determinations that must include Knox-Keene "Your Rights" attachment to inform beneficiaries of their appeal rights. - An email (08/13/20) which includes a description of the MCP's periodic review process. "Pharmacy submits weekly reports to Compliance to ensure timeliness and denial compliance. The denial compliance is reviewed for appropriate denial language and the Knox-Keene "Your Rights" attachment. Additionally, MCP reviews the Knox-Keene attachments on an annual basis to ensure compliance with any updated APLs." - Weekly Summary PA Report, "PA Timeliness Summary" (07/27/20, 08/03/20 and 08/10/20) as

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
periodic review to ensure compliance with Contract requirements and *APL 17-006* regarding grievance and appeal requirements. When a Plan provides members with incorrect information about their rights, it could delay their care and negatively affect their health outcomes. **Recommendation:** Revise and implement policy and procedures to ensure use of Knox-Keene "Your Rights" notice. Furthermore, revise Plan's pharmacy prior authorization system to send members and prescribers the Knox-Keene "Your Rights" notice. Perform periodic review of the NOA/NAR letters issued to ensure compliance with DHCS requirements.				evidence that the MCP is monitoring denial compliance for appropriate language and the Knox-Keene "Your Rights" attachment. - Internal Report, "DHCS Knox-Keene "You.r Rights" Annual Review" (08/13/20) which ensures compliance with DHCS requirements. **This finding is closed**.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
1.2.2. Finding Pharmacy Prior Authorization Lacked Medical Necessity Review: The Plan denied a pharmacy prior authorization without medical necessity review by a qualified physician or pharmacist. DHCS auditor examined 14 pharmacy prior authorization decisions to verify Plan compliance. DHCS auditor found that the Plan denied a request for Contrave®, which is FDA approved as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in adults, as excluded from Plan coverage. Because Contrave® is a drug used for weight loss, the Plan should have evaluated this drug request for medical necessity. The Medi-Cal FFS list of contract drugs covers	**1.2.2** Policy and Procedure PH 70.0 PHC-CA Prior Authorization Policy was updated to include specific language to address medical necessity review (Procedure Section 3c). Pharmacy staff were provided training with a copy of the updated policy.	**1.2.2** 1. Policy and Procedure PH 70.0 PHC-CA Prior Authorization Policy 2. Pharmacy Training Log	**1.2.2** 7/20/2020	**08/03/20** – The following documentation supports the MCP's efforts to correct this deficiency: - Training Log, "Pharmacy Staff Training Log" (07/20/20) as evidence that the Pharmacy Staff received training regarding the medical necessity review procedures for drugs used for anorexia, weight loss, or weight gain. **08/20/20** – The following additional documentation submitted supports the MCP's efforts to correct the deficiency: - Recently Developed P&P, "PH 70: PHC-CA Prior Authorization Policy" (Effective 07/01/19) (Approved by MCP 07/27/20) to include a section on medical necessary review. "If a drug-specific PA guideline criteria does not currently exist, requests of a non-formulary medication will be reviewed based on medical necessity (e.g. agents used for anorexia, weight loss, or weight gain)."

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
agents used for anorexia, weight loss, or weight gain when these agents are medically necessary. However, the Plan's formulary did not cover agents used for anorexia, weight loss, or weight gain when these agents are medically necessary. The Plan did not know the Medi-Cal program provides medical necessity coverage for drugs used for anorexia, weight loss, or weight gain. Additionally, the Plan's policy PH 2.2, *California Formulary Policy* (eff. 1/1/18) did not identify the medical necessity review procedures for drugs used for anorexia, weight loss, or weight gain are covered. Lastly, the Plan did not train its pharmacy prior authorization staff to review medical necessity requests for drugs used				- Revised P&P, "PH 1.5:PHC-CA Pharmaceutical Services Policy (07/20/20) which has been revised to include drugs requested that are not on MCP's formulary and the prescriber considers the drug(s) medically necessary, the provider has to submit a request to PHC CA for review. In addition, the prior authorization/formulary exception request will be given a response within 24 hours of a request by telephone or other telecommunication device. - Formulary List, "PHC-Comprehensive Formulary (List of Covered Drugs)", (Effective 01/01/20) as evidence that agents used for anorexia, weight loss, or weight gain are listed as a covered drugs. Agents such as Contrave (Naltexone) and Megace (Megestrol). **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
for anorexia, weight loss, and weight gain. When the Plan incorrectly denies requests for covered drugs that are medically necessary, the member does not receive the medically necessary medication. **Recommendation:** Revise and implement policy and procedures to ensure proper handling of medical necessity reviews for drugs used for anorexia, weight loss, or weight gain. Properly train pharmacy prior authorization staff to review medical necessity requests for drugs used for anorexia, weight loss, or weight gain. Lastly, update Plan formulary with its PBM, to ensure proper claims adjudication.				

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
1.2.3 Finding - Written Notification to Prescribing Providers: The Plan did not communicate the decisions to prescribing providers initially by telephone or facsimile, and then in writing. DHCS auditor examined 14 pharmacy prior authorization decisions to verify Plan compliance. The Plan did not communicate their decision for pharmacy prior authorization request to prescribing providers in three out of 14 samples. The Plan explained that the Plan's staff monitored for facsimile failure daily and reached out to the prescribing providers for alternative notification. However, the Plan was not able to provide documentation to support that an alternative	**1.2.3** Policy PH 70.0 Prior Authorization Policy was updated to include specific language to address provider notifications (Procedure Section 5e). For any failed fax, the pharmacy service coordinator is instructed to reach out to the provider to obtain an alternative fax number. The failed fax queue is monitored daily. Pharmacy staff were provided training with a copy of the updated policy.	**1.2.3** 1. Policy and Procedure PH 70.0 Prior Authorization Policy 2. Pharmacy Training Log	**1.2.3** 7/20/2020	**08/26/20** – The following documentation supports the MCP's efforts to correct this deficiency: - Recently Developed P&P, "PH 70: PHC-CA Prior Authorization Policy" (Effective 07/01/19) (Approved by MCP 07/27/20) to include a section on written notification to prescribing providers. "PHC shall provide communication to the prescribing provider via telephone or facsimile within 24 hours of a decision to approve. For decisions resulting in a denial, deny or modification, a written response (NOA) shall be provided to the prescribing provider within two business days of the decision." - Desktop Procedure, "Failed Fax Process" (08/20) as evidence that the MCP has a quality assurance process to ensure alternative provider notification takes place when facsimile communication failed. - An email (09/18/20) which is an example of the MCP's process for notating the date and time the alternative notation was sent to

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
notification was provided and therefore the Plan did not call or send written notification to prescribing providers. The Plan's policy PH 10.3, *Coverage Determinations & Redeterminations for Drugs and Therapeutic Devices* (eff. October 2018), did not identify the procedures for handling unsuccessful facsimile communication to prescribing providers. In addition, the Plan did not implement a quality assurance process to ensure alternative provider notification took place when facsimile communication failed. The Plan did not send the written pharmacy prior authorization notice to prescribing providers. This causes prescribing providers to not be aware				prescribing provider. - Attestation Log, "Pharmacy Training" (08/24/20) as evidence that Pharmacy staff received guidance on the process of correcting and resending failed faxes. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
of the denied pharmacy prior authorization requests and impairs members' ability to initiate an appeal. **Recommendation:** Revise and implement policy and procedures to ensure the Plan's pharmacy prior authorization decisions are communicated to the prescribing provider initially by telephone or facsimile, and then in writing.				
2. Case Management and Coordination of Care				
2.1.1 Finding - Completion of Initial Health Assessment Finding: The Plan did not monitor to ensure completion of IHA within 120 calendar days by a PCP as required. DHCS auditor reviewed 14	**2.1.1** Policy and Procedure CM 33.2 PHC-CA IHEBA-Initial Health Assessment with PCP was revised to reflect the monitoring and completion of the Initial Health Assessment (IHA) within 120 calendar days of	**2.1.1** 1. Policy and Procedure CM 33.2 PHC-CA IHEBA-Initial Health Assessment with PCP	**2.1.1** 9/1/2020	**08/03/20** - The following documentation supports the MCP's efforts to correct this finding: -Updated P&P, "CM 33.2: PHC-CA IHEBA-Initial Health Assessment with PCP" (05/31/20), which has been

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
member's IHA records and found that the Plan did not monitor completion of IHA by PCP. The Plan used a monitoring report to track IHA completion. However, the monitoring report indicated "N/A" for members' identify as having a completed IHA. The Plan stated the "N/A" was because the Plan did not have an electronic method to verify IHA completion. During the interview, Plan stated that they do not have a procedure to monitor IHA completion within the required timeframe. Without monitoring IHA completion, the Plan cannot ensure that each member completed IHA within the 120-calendar day timeframe, which can delay member's care.	enrollment. The IHA is completed by the Provider using the Staying Healthy Assessment Tool which is part of the EMR. The Provider will complete and sign off on the IHA. The Plan will monitor completion by use of a report generated to reflect the IHA. This will be reported on a quarterly basis to the Compliance Department. Additional training of this requirement will be completed by 4th quarter of 2020 by the Provider Relation Department. Monitoring of IHA completion is slated to be standing item on the Joint Operations Meeting of the Plan and Department of Medicine beginning September 2020.			amended to include a section on monitoring activities: "IHA Rates are calculated at minimum biannually and presented to quality committees for review. Monthly completion rate reports with member detail are distributed to the Chief of Managed Care, Vice President of Managed Care Operations, Medical Directors, and the Utilization and Care Coordination staff, and it's RNCTM." (Page 3) **08/31/20** – The following additional documentation submitted 08/31/20 supports the MCP's subsequent efforts to correct this finding: 1. A review of ALL PHC PLAN Members for the Initial Health Assessment current status. Those members who did not complete the Assessment Tool with their Provider will be identified and mitigated. Care Management staff will follow these members and schedule a visit in 2020. 2. Once the initial review of the

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
Recommendation: Revise and implement policy and procedures for monitoring and ensuring the completion of IHA within 120 calendar days of enrollment.				assessments is completed, a monthly report of completed Initial Health Assessments will be sent to the Associate Director of Care Coordination for review. This report will be created by IT using data pulls from the AHF EMR. For in-network Providers, a manual review of these assessments will take place monthly by accessing the Plan's appropriate chart review. 3. PHC will follow all newly enrolled members for completion of the Initial Health Assessment within 120 days by monitoring the report mentioned above. - MCP's ongoing monitoring will include procedures described in P&P "CM 32.3": "IHA Rates are calculated at minimum biannually and presented to quality committees for review. Monthly completion rate reports with member detail are distributed to the Chief of Managed Care, Vice President of Managed Care Operations, and Medical Directors as well as the Utilization and Care Coordination staff and its

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				RNCTM." (Page 3) - The MCP submitted an EMR system screenshot to demonstrate available tools for the completion of the IHA. A screenshot is taken from the AHF EMR showing the Staying Healthy Assessment. The Provider reviews this Assessment with the Member. (E-mail 08/31/20) - The MCP confirmed that the monthly report is currently in development with Information Technology (IT). However, due to the relatively small size of PHC-CA enrollment, the Plan will manually monitor these members for completion of the IHA, within the required timeframe, - Q3 Managed care Compliance Committee Agenda (September 8, 2020) shows agenda item for discussion "PHC-CA IHA Completion Report" (E-mail 08/31/20, Attachment A.) - PHC-CA's Provider Relations Department will orient all Primary

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				Care Providers (PCP's) to the Staying Healthy Assessment as part of the standard new provider orientation (Attachment B "Sample Attestation form") and as part of the annual training sessions scheduled for 3rd quarter of every year. Internal PCP's will complete the Assessment form utilizing AHF's internal CPS system. External PCP's will complete the paper version of this Assessment for submission to AHF's Clinical Department (Attachment C, "SHA Template"). - PHC-CA has requested the addition of Staying Health Assessment Discussion as a standing item for the Joint Operations Meeting with the Department of Medicine and Managed Care. This request was made to the Executive Assistant to the Chief Medical Officer & Deputy Chief Medical Officer for the addition of Staying Health Assessment Discussion as a standing item for the Joint Operations Meeting with the

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				Department of Medicine and Managed Care responsible for the agenda for this meeting. The September meeting is currently scheduled for September 10, 2020. **The finding is closed.**
2.4.1 Finding - Completion of Physician Certification Statement Form: The Plan did not complete a PCS form before providing NEMT services to members. In addition, the Plan did not follow its policy and procedures, which states the PCS form must be completed before NEMT can be prescribed or provided. Neither the DHCS nor Plan's approved PCS form was used. The Plan explained that its computer system for arranging NEMT services contains components	**2.4.1** Policy and Procedure CM 43.2 PHC-CA Transportation Benefit was updated to include a process for tracking and completion of NEMT PCS forms. The Plan confirmed PCS form completion for all members receiving NEMT transportation for ongoing medical appointments.	**2.4.1** 1. CM 43.2 PHC Transportation Benefit_draft 2. NEMT Tracking Log	**2.4.1** 2/11/2020	**08/03/2020- The following documentation supports the MCP's efforts to correct this finding:** **-** Updated P & P, Policy Number: CM 43, Policy Title: PHC-CA "Transportation Benefit" has been amended to include procedure as it relates to NEMT transportation request for tracking and completion. Upon the request for NEMT, a member services representative will notify the Utilization Management Review of whom will be responsible for reviewing the medical necessity in addition to ensuring the completion of the Physician Certification Statement. Member services will work with the UA Team on proper authorization for

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
required in the PCS form. Therefore, the Plan did not complete the PCS form before providing NEMT services to members. However, the computer system only included some of the required components of the PCS form. Without a completed PCS form from the treating physician, the appropriate level of service for members may not be determined; therefore, the members' medical transportation needs may be compromised. **Recommendation:** Implement policies and procedures to ensure the use of DHCS approved PCS form and ensure that PCS forms are completed before NEMT services are provided.				NTM and to verify all timelines are met. Member services will contact the transportation agency through necessary means, i.e. Telephone or online website and make the reservation. Upon the reservation confirmation member services contact the beneficiary with complete details and contact information (pg. 4-5). - Sample NEMT Tracking Log is evidence of the MCP monitoring the PCS Forms for NEMT. **08/14/2020- The following additional documentation submitted supports the MCP's efforts to correct this finding:** - Training Agenda (02/11/2020) as well as attending staff serve as evidence of the MCP providing NEMT Transportation Training. - Updated P & P, Policy Number: CM 43; Policy Title: PHC-CA Transportation Benefit, (10/16/2019) which has been amended to outline the procedures as they pertain to the

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				NEMT tracking log. (Page 4, section 3) - Sample DHCS Approved NEMT Justification Template and DHCS Approved Memo is evidence of the MCP having updated PCS forms that have been implemented for the NEMT Services. **This finding is closed.**
2.4.2 Finding - Medi-Cal Program Enrollment of NEMT Provider: The Plan did not ensure that its NEMT provider was enrolled in the Medi-Cal program as required by APL 19-00. Medi-Cal members can be subject to inadequate and unsafe transportation conditions if the NEMT provider does not undergo the screening process to qualify as a Medi-Cal provider.	**2.4.2** The Plan no longer utilizes NEMT vendor, American Logistics, identified during the Plan's February 2020 onsite audit review with DHCS. The Plan has a letter of agreement (LOA) with a vendor to provide ongoing NEMT services. The Plan has since implemented processes to ensure that all in network providers (including NEMT providers) complete DHCS Enrollment to ensure compliance with DHCS APL 17-019. The Plan has received enrollment confirmations from	**2.4.2** 1. PR 1.3 PHC-CA Network Development and Management (APL 17-019 reference page 3 #11). 2. CR 501.0.0 AHF Provider Screening and Enrollment Program 3. Provider	**2.4.2** 5/1/2020	**08/03/20**- The following documentation supports the MCP's efforts to correct this finding: - Updated P&P's, "Policy Title: "Provider Screening and Enrollment Program" and "Network Development and Management Policy" have both been amended to support necessary screening and enrollment requirements including NEMT. The P&P outlines (Page 3 Sec 11a) that the MCP shall verify that all network specialist that have contracted with the plan comply with DHCS Provider

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
Recommendation: Develop and implement policy to require NEMT providers to enroll in the Medi-Cal program and monitor to ensure that all NEMT providers are enrolled**.**	all providers active in the Plan's network as a result of completed AHF's Provider Screening and Enrollment Attestation. The Plan requires all new providers contracted with the Plan to complete the Provider Screening and Enrollment Attestation during the initial contracting review process. Existing providers are required to resubmit and recertify the accuracy of the individual provider's enrollment information as part of the recredentialing review process. In addition, the Plan is in active contract negotiations with NEMT providers Lyft and Call The Car. Call The Car has confirmed DHCS enrollment and Lyft has advised the Plan of their enrollment under the 1135 waiver and is in active discussions with DHCS concerning permanent enrollment processes. The Plan will ensure receipt of DHCS Enrollment for Lyft and Call The Car prior to contract	Screening and Enrollment Attestation. 4. Lyft's statement re_ DHCS + Medi-Cal enrollment response.		Credentialing/Re-credentialing Screening Requirements outlined by APL 17-019. As well as necessary requirements of all network specialist being required to complete the Medi-Cal Screening and Enrollment Provider Attestation during the contracting period. Existing providers are required to confirm enrollment when the re-credentialing processes is being managed. (CR 1). Medi-Cal Screening and Enrollment Provider Attestation is required for all new providers contracting with the Medi-Cal Network. In addition, those providers in the existing network have also completing the attestation as of August 1, 2020. - Sample Report, "AHF/PHC Provider Types Requiring Medi-Cal Enrollment" has been created to assist the MCP with tracking to confirm documents have been received. The MCP must revalidate the enrollment of each of their limited-risk and medium-risk network providers at least every five years in the verification

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	activation for Plan's Medi-Cal Network.			and revalidation process. (CR_Provider Screening Enrollment P. 6 Sec J) **09/04/20**- The following additional documentation submitted supports the MCP's efforts to correct this finding: - Letter of Agreement eff. 08/12/20 is evidence of the MCP's new transportation provider- Call the Car (CTC). The LOA is the interim contract as the plan is working on negotiations for the formal agreement with the provider CTC that will include Medi-Cal and Medicare enrollees, in addition to membership for the plan outside the state of CA. Due to the expansion, the plan has delayed the contract. - An email (09/04/20) which includes a description of the MCP's new contract that has been established with Kiriworks, this is a 3rd part vendor, that will oversee monitoring and tracking of incoming forms and attestations documents. This new system

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				should go into place by the end of the year. **This finding is closed.**
2.5.1 Finding - Processing and Completing Requests for COC: The Plan did not monitor to ensure members requests for COC are processed and completed within the timeframes as required by *APL 18-008*. Review of the Plan's COC files indicated the Plan did not have procedures for processing member's COC requests within the required timeframes. During the interview, the Plan acknowledged that they do not have a process to monitor and ensure member's COC requests are completed within the required timeframes.	**2.5.1** Policy and Procedure MS 16.1 PHC-CA Continuity of Care – Coordination of Services was updated to reflect the requirements outlines in DHCS APL 18-008. AHF has implemented a monitoring process (Monitoring, page 3) via the Continuity of Care ("COC") log. Additionally, the COC requests will be reported out at the quarterly Utilization Management and Managed Care Compliance Committee to ensure they are processed and completed pursuant to APL 18-008 requirements.	**2.5.1** 1. MS 16.1 PHC-Continuity of Care – Coordination of Services_draft 2. COC Tracker 3. Q3 UMC Agenda 4. Q3 Compliance Committee Agenda	**2.5.1** 7/20/2020	**08/03/20** - The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "MS 16: PHC-CA Continuity of Care – Coordination of Services" which has been amended to include timeframes for processing member Continuity of Care (COC) requests (page 2): Timeline begins within five (5) working days of the date when PHC Member Services or Care Coordination starts the process to determine if the member has a pre-existing relationship with provider and completed within thirty (30) calendar days. If there is risk of harm to the member (defined as imminent/serious threat to health), process will be completed within three (3) calendar days.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
Without procedures for timely completion of member's requests for COC, the members may experience a delay or interruption of medically necessary services. **Recommendation:** Revise and implement policy to include all required timeframes to ensure member's requests for COC is in accordance to *APL 18-008*.				If the member's medical condition requires more immediate attention but is not defined as imminent/serious threat, process will be completed within fifteen (15) calendar days. In addition, the MCP also has implemented steps for monitoring (page 3): Member Services and Care Coordination team will receive, document and monitor requests for Continuity of Care for new members. Associate Director of Care Coordination will review for meeting criteria. Registered Nurse Care Team Manager (RNCTM) will monitor and document the process on the COC LOG. Reporting of Continuity of Care Requests and outcomes will be submitted to the Utilization Management and the Managed Care Compliance Committee routinely at quarterly scheduled meetings. Utilization Management Committee members will review data and provide oversight and feedback to facilitate improved quality operations to

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				access, continuity and coordination trending and utilization efforts. - Excel Spreadsheet Tracking Log, "COC Tracker Final" as evidence that the MCP is monitoring to ensure members requests for COC are processed and completed within the timeframes as required by APL 18-008. The tracking log includes a column where it tracks the COC Completion Date. - Meeting Agenda, "Utilization Management Committee Meeting" (08/31/20) in which the MCP has added "Continuity of Care (COC) Requests" as a standing agenda item as part of the MCP's process to monitor the member's requests for COC are processed and completed within the timeframes as required by APL 18-008. - Meeting Agenda, "Managed Care Compliance Committee Meeting Agenda" (09/08/20) in which the MCP has added "COC Tracker" as a standing agenda item as part of the MCP's process to monitor the member's requests for COC are

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				processed and completed within the timeframes as required by APL 18-008. **This finding is closed.**
3. Access and Availability of Care				
<u>3.4.1 Finding - Member Notification on Pharmacy Provider Termination:</u> The Plan policy PH 1.4, *Guidelines for Provision of Pharmaceutical Services* (eff. 1/1/2018) did not identify the procedures for pharmacy terminations. Moreover, the Plan's policy also did not specify that the Plan shall send affected member a written notice of termination of a contracted pharmacy provider within 15 calendar days after receipt or issuance of the termination notice. Therefore, the Plan's policy did not comply with Contract requirement and	**<u>3.4.1</u>** Policy and procedure PH 1.5 PHC-CA Pharmaceutical Services Policy was updated to include specific language regarding the notification of terminated contract providers (Procedure Section 7c). Additionally, Policy and Procedure MS 13.2 Enrollee Notification for Changes in Availability or Location of Covered Services was updated to outline notification requirements of provider/pharmacy terminations and ensure collaboration with our PBM to determine whether any enrollees are impacted by the pharmacy termination (Procedure Section 2).	**<u>3.4.1</u>** 1. PH 1.5 PHC-CA Pharmaceutical Services Policy 2. MS 13.2 Enrollee Notification for Changes in Availability or Location of Covered Services_Draft 3. Network Pharmacy Termination Notice DHCS MMDDYY PHC FR Form 36.0 4. Pharmacy	**<u>3.4.1</u>** 7/20/2020	**8/3/20** - The following documentation supports the MCP's efforts to correct this finding: - Policy PH 1.5 was updated to include language regarding sending written notification of pharmacy termination to members within 15 calendar days after receipt of the termination notice. - Policy MS 13.2 was updated to describe the MCP's notification requirements of provider/pharmacy terminations. The updated policy ensures collaboration with the PBM to determine impact to the member. - Network Pharmacy Termination Notice template that is used when the MCP needs to notify a member of a network pharmacy termination. - Pharmacy training log serves as

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
CFR, Title 42, section 438.10(f)(1). During the interview, the Plan was not aware of the Contract requirement and requirements set forth in CFR, Title 42, section 438.10(f)(1) regarding provider terminations and timely written member notice of termination of a contracted provider applies to pharmacy providers. The Plan's failure to identify procedures to terminate network pharmacies and to send affected members timely written notice of termination of a contracted pharmacy provider may adversely affect member health outcomes. **Recommendation:** Revise and implement	Pharmacy staff were provided training with a copy of the updated policy.	Training Log		evidence pharmacy staff was trained on the updated procedure on July 20, 2020. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
policy and procedures to address pharmacy provider termination and the need to send affected members timely written notification of pharmacy termination to comply with amended federal regulation. Develop a quality assurance process to ensure the Pharmacy Benefit Manager complies with amended federal regulation				
4. Member Rights				
4.1.1 Finding - Submit Copies of All Grievances Alleging Discrimination to DHCS: The Plan did not submit copies of grievances alleging discrimination to DHCS for review and	**4.1.1** Policy and Procedure RM 7.1 PHC-CA Member Grievance Process was updated to include the procedure to submit copies of grievances that allege discrimination against the member to DHCS. The process	**4.1.1** 1. Policy and Procedure RM 7.1 PHC-CA Member Grievance Process	**4.1.1** 2/13/2020	**8/3/20** - The following documentation supports the MCP's efforts to correct this finding: - Policy RB 7.1 was updated to include procedures for submitting grievances alleging discrimination to DHCS. The MCP will submit the grievance to DHCS within 10 days

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
appropriate action as required by the Contract. DHCS auditor reviewed 23 grievance files for appropriate action and identified a grievance complaint alleging discrimination reported by a member; however, the case was not submitted to DHCS. By not submitting grievances alleging discrimination, DHCS will not have the opportunity to review and implement appropriate action. **Recommendation:** Revise and implement policy to include procedures to submit copies of grievances alleging discrimination against a member, or eligible member, to DHCS for review and appropriate action.	is outlined on Page 5 of the Policy and Procedure. Additionally, the Plan added column "X" on the Grievance Log to track grievances that allege discrimination against members to ensure compliance with the reporting requirements.	2. 2020 AHF DHCS Medical Audit CAP-Grvc Log Temp		of mailing the resolution letters to the member. The MCP's submission includes the original grievance, provider's response, contact info from MCP staff responsible for investigating and responding the grievance, contact info for the accused party and all correspondence with the person filing the grievance including the acknowledgment and resolution letters. - Updated grievance log now includes a column for tracking grievances alleging discrimination. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
4.1.2 Finding: Documentation of Medical Director Involvement in the Resolution of QOC Grievances: The Plan used a Complaint, Grievance and Appeal ICF to document the review and resolution by the Medical Director. The Plan explained that QOC grievances are reviewed during their weekly “Medical Administration” meetings with the participation of the Plan’s Medical Director and/or Medical Consultant staff. The Plan believed that the meeting was sufficient review of QOC grievances. Therefore, the Medical Director did not complete the required sections on the ICF. Without the documentation by a	**4.1.2** The Grievance Investigation Case Form ("ICF") was updated to include a mandatory section where any Quality of Care ("QOC") Grievances must have a Medical Director's Clinical Review in order for the ICF form to be considered complete.	**4.1.2** 1. Grievance Investigation Case Form	**4.1.2** 2/13/2020	**8/3/20** - The following documentation supports the MCP’s efforts to correct this finding: - Updated Grievance Investigation Case Form now includes a field for quality of care grievances where Medical Directors are required to confirm their review in order for the form to be considered complete. **9/15/20** - The following additional documentation supports the MCP’s efforts to correct this finding: - Email from MCP dated 9/12/20 describes process for monitoring Medical Director review of QOC grievances. The MCP monitors through the use of a Case Classification monitoring report that is updated on a monthly basis. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
health care professional with appropriate clinical expertise treating the member's condition or disease, the member's grievance complaint with clinical aspects may not be properly resolved and therefore may adversely affect the member's health. **Recommendation:** Ensure implementation of policy and procedures to document the Medical Director's involvement in the review and resolution of all QOC grievances.				
5. Quality Management				
N/A				

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
6. Administrative and Organizational Capacity				
N/A				
State Supported Services				
N/A				

Submitted by: Sandra Holzner **Date: August 3, 2020**
Title: Compliance Manager