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

MICHELLE BAASS
DIRECTOR

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June 17, 2022

Ann Warren, Associate Chief Executive Officer
Community Health Group Partnership Plan
2420 Fenton Street, Suite 100
Chula Vista, CA 91914

RE: Department of Health Care Services Medical Audit

Dear Ms. Warren:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Community Health Group Partnership Plan, a Managed Care Plan (MCP), from June 21, 2021 through July 2, 2021. The audit covered the period of June 1, 2019 through May 31, 2021.

On May 17, 2022, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on October 19, 2021.

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) 345-7825 or Christina Viernes at (916) 345-7833.

Sincerely,

[Signature on file]

Oksana Meyer, Chief
CAP Compliance and FSR Oversight Section
Managed Care Quality and Monitoring Division
Department of Health Care Services

Enclosures: Attachment A, CAP Response Form

cc: Sabrina Sierras, 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

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Plan: Community Health Group Partnership Plan **Review Period: 06/01/2019 – 05/31/2021**

Audit Type: Medical Audit and State Supported Services **Onsite Review: 06/21/2021 – 07/02/2021**

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, as applicable 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
2. Case Management and Coordination of Care				
2.1.1 Monitoring IHA Completion **Finding**: The Plan did not ensure the provision of timely, complete, and comprehensive IHAs	The Plan has developed a desk reference to outline its process to monitor, provide feedback to providers. The process builds on existing technology to provide "report card" type reports to PCPs through CHG's provider portal with the capability to download member level reports. With each bimonthly data refresh, each PCP's IHA completion rate will be posted in the portal. PCPs will be able to download gap reports. The gap reports will include the members' effective date and will be ordered by the oldest effective date, allowing the provider to prioritize their outreach activities. CHG's HEDIS Team will review the IHA completion rate during monthly meetings with high-volume sites along with encounter submission and HEDIS reports. Monthly completion rates of all PCPs will be reviewed during CHG's	**ATTACHMENT**: 1. IHA Process Monitoring 2. IHA Report	Implementation date: Plan developed and finalized on 11/17/2021. Target implementation date: 01/31/2022	**04/04/2022 -** The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES**: • P&P "IHA Process Monitoring" outlines the following: o The policy states "CHG must cover and ensure the provision of an IHA to each new member within 120 days of enrollment. An IHA consists of a comprehensive history and physical examination, preventive services, and an Individual Health Education Behavior Assessment (IHEBA)." (Note: the Staying Healthy Assessment or SHA is DHCS' version of the IHEBA.) (Contract, Exhibit A, Attachment 10(3) and Policy Letter 08-003 Initial Comprehensive Health Assessment) o On a quarterly basis, the completion of IHAs and IHEBAs within the designated timeframe through encounter

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	Total Quality Improvement Work Group meetings and action will be taken when appropriate.			data (statistical claims) submitted by each primary care site. o The following codes are used in monitoring for the IHAs and IHEBAs: New Patient: Initial Health Assessment: 99381-99387 (Initial comprehensive preventive medicine evaluation) and Individual Health Education Behavioral Assessment: 96156 (as of 11/01/2020) Established Patient: Periodic Health Assessment: 99391-99397 (Periodic comprehensive preventive medicine evaluation) and Individual Health Education Behavioral Assessment: 96156 (as of 1/01/2020) o The report generated on a quarterly basis will be used to create a “report card” per PCP to depict their IHA and IHEBA completion rate. o PCPs will be able to download gap reports. The gap reports will include the members’

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				effective date and will be ordered by the oldest effective date, allowing the provider to prioritize their outreach activities. o CHG's HEDIS Team will review the IHA completion rate during monthly meetings with high-volume site along with encounter submission and HEDIS reports. o Monthly completion rates of all PCPs will be reviewed during CHG's Total Quality Improvement Work Group meetings and action will be taken when appropriate. **TRAINING & IMPLEMENTATION:** • Total Quality Improvement Work Group Excerpts outlines the following: o Deficiencies are discussed & next steps are developed per PCP to ensure IHA's are taking place in a timely matter. **MONITORING & OVERSIGHT:** • P&P "IHA Process Monitoring"

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				○ The report generated on a quarterly basis will be used to create a “report card” per PCP to depict their IHA and IHEBA completion rate. ○ The reports generated will be reviewed during monthly meetings. • Various emails & letters to PCPs regarding Encounter numbers demonstrate the Plan has procedures to notify PCPs of their current rating of completion based on data submitted, showing the Plan is proactively monitoring & tracking encounter data. • Provider Portal Encounter Report: ○ The report demonstrates the Plan’s encounter tracking portal & includes all active members & indicates whether an encounter has been received for the current calendar year. The report is refreshed weekly. • IHA Report: ○ The sample report demonstrates the updates the Plan has made, including a

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				summary displayed, "As part of your contract with CHG and mandate by the State (Department of Health Care Services), an IHA must be completed within 120 days for Medi-Cal members and 90 days for Medicare members from the date of program eligibility and annually thereafter or within the periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures for ages two and younger whichever is less." The summary ensures the PCP is aware of the timely manner IHAs are to be completed. **This finding is closed.**
2.2.1 Provision of Complex Case Management Services **Finding**: The Plan did not ensure the provision of Complex	The Case Management Department Management staff reviewed the Complex Case Management Program (CCMP) processes with the Medical Directors, CMO, and COO. During the third quarter of 2021, processes were	**ATTACHMENT**: 2.2.1 7255.1a - Complex Case Management_ Redline 11-10-21 (Word)	Process Implementation Date: Q3, 2021 Policy Implementation: As soon as approved by	**11/22/21** - The following documentation supports the MCP's efforts to correct this finding: POLICIES and PROCEDURES: - Policy 7255 has been revised to include: • Updates to the review and

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Case Management services	improved around the CCMP referrals for our Non-SPD Medi-Cal population. Addendums have been made to our Policies to reflect the current population engaged in the program and these modifications to our processes. Members referred to CHG for CCMP are being reviewed and triaged by a Clinician. All the members identified as qualifying candidates for the CCMP are being assigned to a Clinical Case Manager and contacted within 30 days of the identification, and are offered the opportunity to enroll in CCMP. The member is outreached three times to discuss the program. The CCMP is voluntary, and it is based on the active participation of the member. Members have the option to opt-out of case management		DHCS.	identification process: All the members identified as qualifying candidates for the CCM program will be assigned to a Clinical Case Manager and contacted within 30 days of the identification, and will be offered the opportunity to enroll in Complex Case Management. Case Management Systems: The Case Manager assigned to the case will complete a re-assessment of the case and outcomes 60 days after the enrollment in the CCM Program; if by then, the member has completed all of the goals and interventions set up during the Interdisciplinary Care Team (ICT) Presentation. Then, the case will be closed and transitioned to Primary Care for Basic Case Management. • If the member continues to require case management services, they will remain with ongoing case management as they continue to require

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	services at any point. The Case Manager assigned to the case will complete a re-assessment of the case and outcomes 60 days after the enrollment in the CCMP; if the member has completed all of the goals and interventions set up during the ICT Presentation, then the case will be closed and transitioned to Primary Care for Basic Case Management. However, if the member continues to require goals and interventions, they will remain with ongoing case management. For further information, please refer to the policy submitted – Complex Case Management 7255.1.a			interventions or meet the criteria. **3/9/22**- The following additional documentation supports the MCP's efforts to correct this finding: - Email communication from 3/9/22, MCP confirmed it has moved its management of CCMP to CHGNet as planned. In collaboration with the MCP's Informatics Department, the assignment of Complex Case Population was deployed in the MCP's internal Core Case Management System (CHGNet). As a result, it is being used by the assigned Clinical Case Managers and Management Team. **04/25/22** – MCP's written response confirmed the CHG's implementation of the changes in Policy 7255.1.a Complex Case Management. **This finding is closed.**
3. Access and Availability of Care				

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3.8.1 Non-Emergency Medical Transportation **Finding:** The Plan did not have a policy to ensure subcontractors offer door-to-door services for members.	During the root cause analysis, the Plan identified a current transportation provider's executed contract (3/19/2020) stating; "gurney service shall be all inclusive of door-to-door and wait time." The following applicable policies have been revised to comply with APL 17-010 NEMT/NMT: The New Provider Orientation policy was update to indicate the following: "door-to-door escort for members (transportation providers)". The Member Services NEMT/NMT policy was revised to indicate the following: "Functional limitation justification, when arranging for non-emergency medical transportation (NEMT), the Plan will review the Physician Certification Statement (PCS)	**ATTACHMENT**: 3.8.1a Black Tiger Limo - Replacement Contract - Eff. 03.01.20 (PDF) 3.8.1b 5101a New Provider Orientation 3.8.1c 5101a New Provider Orientation_RL (Word) 3.8.1d 6059 Mbr Serv - NEMT and NMT Approved by DHCS (PDF)	Implementation Date: 3/1/2020 Implementation Date: 10/04/2021 Implementation Date: 7/19/2021	**11/19/21** – The following documentation supports the MCP's efforts to correct this deficiency: **Amended Policy and Procedures** - Amended Policy, "5101a: New Provider Orientation" (10/01/21) which has been amended to include Door-to-Door Escort for members (Transportation Providers) as a topic to be discussed at the provider orientations. **Written Agreement** - Provider Agreement, "Black Tiger Limo, INC." (03/19/20) describes covered services/compensation rates, which includes gurney services shall be all inclusive of door-to -door escort and wait time. - PCS Form, "NEMT – Physician Certification Statement Form" (12/21/21) requires function limitation justification. The Physician is required to document the member's limitations and provide specific physical and medical limitations, which advises transportation provider

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	form submitted by the provider to determine the need for doo-to-door assistance for members who cannot reasonably ambulate or are unable to stand or with without assistance".			if door-to-door services is to be rendered to the member. **01/28/22** – The following additional documentation supports the MCP's efforts to correct this deficiency: **Amended Policy and Procedures** - Amended Policy, "6059: Non-Emergency Medical Transportation & Non-Medical Transportation" (01/27/22) which has been amended to include a section on door-to-door assistance will be performed by the transportation provider and the Plan will ensure door-to-door assistance is being provided by running a quarterly utilization report based on claims paid for door-to-door patient attendant/escort services. **Monitoring/Oversight** - Monitoring Report (01/27/22) which ensures transportation providers are providing door-to-door services. The report tracks NEMT authorization reported, NEMT escort/door-to-door services paid, and % of trips with escort/door-to-door services provided.

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				This finding is closed.
3.8.2 Medi-Cal Enrollment of NEMT and NMT Providers. Finding: The Plan did not ensure contracted NEMT and NMT providers were enrolled in the Medi-Cal program.	All NEMT and NMT providers are confirmed to be Medi-Cal enrolled prior to receiving a contract. Credentialing and Contracting confirms Medi-Cal enrollment as part of their pre-cred process. In addition, the enclosed Pre-Cred desk reference was updated to include Transportation Providers.	**ATTACHMENT**: 3.8.2 Pre-Cred Desktop Procedures	Implementation date: 11/1/2021	**05/17/2022 -** The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** • **Pre-Cred Desktop Procedures** – the procedure document outlines that the Plan was revised to include "Transportation providers" as part of ways to receive Pre-Creds through contracting. (Page 1, section Ways to Receive Pre-creds (b.)) o This procedure document ensures that the Plan is pre-credentialing providers & properly reviewing, inclusive of Transportation providers, "to make sure there are no issues against their License, Sanctions or Databank information." (Page 1) • **P&P 7715 Medi-Cal Provider**

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				Enrollment – the policy outlines that the Plan ensures all contracted providers for Medi-Cal line of business are enrolled in the Medi-Cal program. • The policy outlines the Plan's procedures of enrollment by DHCS, where the Plan confirms enrollment via the open data portal during the initial credentialing & recredentialing process. (Page 1, Procedure, 1.(a.) • The policy states "If a provider is not enrolled, the specialist will inform the provider about the DHCS enrollment process and follow up to ensure the provider is enrolled within 120 days." (Page 1, Procedure, 1(c)) • The policy also states that other enrollment options will be considered before termination. (Page 1, Procedure, 1(d)) • The Plan stated in its response regarding non-compliance, "Providers will be placed on a CAP if audit results demonstrate instances of non-compliance.

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				Failure to satisfy the requirements specified in the CAP will result in immediate terminate with cause, which is specified in Section 7.4 of all provider contracts." (04-27-22 MCP Response) **TRAINING & IMPLEMENTATION** • New_Practitioner_Orientation_v3 o The New Provider slide deck states the following for Transportation Services: "Community Health Group is required to provide medically appropriate Non-Emergency Medical Transportation (NEMT) Services when the member's physical condition is such that transport by ordinary means of public transportation is required for obtaining medically necessary services. Community Health Group's transportation providers are required to provide NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or

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				crutches. Door-to-door escort/assistance must be provided for all members receiving NEMT services." **MONITORING & OVERSIGHT** • Credentialing Best Practice Guide outlines the Plan's verification process to ensure providers have been enrolled as "Medi-Cal enrolled". • The guide states that if a provider is not yet enrolled, the Plan's "Credentialing Department has to request a copy of the transportation application or approval letter from DHCS stating their NPI number has been submitted for review or approval." • The Plan has an approved transition plan, so to not impact their network/members. **This finding is closed.**

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5. Quality Management				
5.3.1 New Provider Training Requirements Finding: The Plan did not ensure completion of new provider training for newly contracted providers within ten-working-days.	The Plan has taken the actions outlined below: 1. Contracting Administrative Assistant will send out weekly new contract report to Provider Services, Claims Director, HEDIS Manager and Contracting Director. 2. New Provider Orientation status will be tracked monthly through the Compliance dashboard. 3. Policy *5101 New Provider Orientation* was updated to include language on tracking of new provider orientations and handling of orientation for retro-effective contracts. Please refer to clean and redline versions of the updated policy.	**ATTACHMENT**: 5.3.1a 5101a New Provider Orientation (PDF) 5.3.1b 5101a New Provider Orientation_RL (Word)	Implementation Date: 10/04/2021	**04/08/2022 –** The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES:** "Policy 5101a New Provider Orientation - 01.06.22" & "5101a New Provider Orientation 01.06.22 RL": • The P&P outlines that New Provider Orientation will be monitored monthly, as well as, new provider orientation due dates will be tracked weekly. • The policy states if the provider is not able to complete/be reached within 10 working days, outreach attempts & provider correspondence will be documented. • This policy ensures that its new process improvement is in fact documented as previously mentioned. • The P&P was revised & includes the following language "CHG will not assign members to newly contracted PCPs or refer to newly contracted specialty providers

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				until the provider has completed the New Provider Orientation." This ensures that the Plan has a process in place for when a provider has not yet completed the required New Provider Orientation. **IMPLEMENTATION & TRAINING:** "New Provider Orientation Nancy Ly Sign in Sheet" & "New Provider Orientation Lanoi Medical Group Attestation": • The Audit Report noted that a verification study of ten new providers found that two providers did not receive training within the ten-working-days requirement. ○ The Plan provided signed attestations/confirmation, that since these providers have in fact completed the new provider training. **MONITORING & OVERSIGHT:** "Sample Weekly System Set-Up Tracker": • This sample report details the new provider being entered in the

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				system, the steps of where the provider is with being placed into the system & all notes regarding the new provider orientation being pending/completed. • The weekly reporting is reviewed & updated by the Plan's team that includes Provider Services, HEDIS, Contracting, and Claims. This ensures that monitoring/tracking of new provider training for newly contracted providers is taking place & outreach is happening continuously. "Monthly Provider Training Dashboard for Oct – Dec 2021": • The monthly sample report shows newly contracted PCPs & specialists, their effective date, when new provider orientation is due, the date the training took place, the date of signature from the provider, & the date the provider is "active" – fully setup & trained. • The Plan provided its analysis/assessment of newly implemented procedures stating

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				since implementation of monthly tracking of New Provider Orientation, it has led to training providers within the required timeframes 100% of the time. This ensures that monitoring/tracking of new provider training for newly contracted providers is taking place & outreach is happening continuously. **This finding is closed.**
SSS. State Supported Services				
SSS.1 Timely Abortion Claims Reimbursement **Finding**: The Plan did not reimburse abortion service claims timely.	The Plan has taken the actions outlined below: 1. The Plan has created a weekly report to review any pending state-supported services claims to be processed the same week of the received date. 2. The Plan has enhanced its weekly audit reports to incorporate state supported claims to be reviewed for accuracy of payment and	N/A	Implementation Date: 10/04/2021	**12/14/21** - The following documentation supports the MCP's efforts to correct this finding: **Monitoring** - Excel Spreadsheets, "Weekly State Supported Services Pending Report" and "Weekly State Supported Services Denied Report" (12/09/21) as evidence that the MCP is monitoring their claims payment process. The MCP has created a weekly report to review any pending state-supported services claims to be processed the same week of the

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	timeliness.			received date. The MCP has enhanced its weekly audit reports to incorporate state supported claims to be reviewed for accuracy of payment and timeliness (Weekly State Supp Svcs Pend Rpt - 12.09.2021, Wkly St Supp Svcs Paid_Denied Rpt - 12.9.21). **04/29/22** - The following additional documentation supports the MCP's efforts to correct this finding: **Policy and Procedures** - Updated P&P, "7810a: Claims Adjudication System" which has been amended to include how the claims payment process is monitored. CHG's Director of Claims Administration monitors the claims turn-around-times (TAT) on a weekly basis to ensure that at least 95% of claims are processed within 45 working days. All results of monitoring activities are reported to the Compliance department monthly. Should the TAT be out of compliance, the Director of Claims Administration will conduct a root cause analysis and develop a

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				performance improvement plan to get back into compliance (7810a Claims Adjudication System – 2022, Page 1). **Monitoring** - An email (04/29/22) which includes the MCP's latest report for Claims Turn-Around-Times and a description of the MCP's process for ensuring that manual reviews are completed within 45 days. The MCP deployed additional automated workflows, "Robots", to target specific scenarios that may require manual review, such as coordination of benefits. In addition, the MCP created a weekly report to monitor any pending state-supported claims and to distribute to the analysts to work sooner. The MCP also enhanced its weekly pre-check-run audit reports to incorporate state-supported claims to be reviewed for accuracy of payment and timeliness. The Claims Turn-Around-Times report demonstrates that the MCP is averaging 7.6 working days to turn around a claim (4-29-22 MCP Response).

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				This finding is closed.

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Submitted by: Norma Diaz
Title: Chief Executive Officer

Date: November 19, 2021