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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

January 19, 2018

Mr. Michael Schrader, CEO
CalOptima
505 City Parkway West
Orange, CA 92868

RE: Department of Health Care Services Medical Audit

Dear Mr. Schrader:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of CalOptima, a Managed Care Plan (MCP), from February 6, 2017 through February 17, 2017. The survey covered the period of February 1, 2016 through January 31, 2017.

On January 10, 2018, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on November 16, 2017.

All items have been reviewed and found to be in compliance. The CAP is hereby closed. 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) 552-8946 or Joshua Hunter at (916) 440-7587.

Sincerely,

Jeanette Fong, Chief
Compliance Unit

Enclosures: Attachment A CAP Response Form

cc: Kryzen Vue, 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: CalOptima

Audit Type: DHCS Medical Audit and State Supported Services **Review Period: 02/01/16 – 01/31/17**

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 via email in word format which 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 long term corrective action or a period of time longer than 30 days to remedy or operationalize, 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.

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* (*anticipated or completed)	DHCS Comments
1. Utilization Management				
1.2.1. The language in Notice of Action (NOA) letters to Members were not clear and understandable	<u>UM Response</u> In order to address the identified finding, the Plan's Utilization Management (UM) department established an internal workgroup of specialized staff in October 2016 to develop clear and understandable language in	<u>UM Documents:</u> 1_Denial Appeal Exercise With Answers 1_Denial File Review Challenges PPT	<u>UM Implementation</u> N/A N/A	**12/18/17** – The following documentation supports the MCP's efforts to correct this finding: **<u>Medical</u>** - Audit Tool Instructions and corresponding audit tool as evidence that the plan has developed a

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	Notice of Action (NOA) letters. The internal workgroup developed an audit tool to conduct random and routine monthly audits to review the components of the NOA letters to assess and validate that the Plan is providing actions and decisions in a clear and understandable language to the Plan's members in accordance with CA Health and Safety Code Section 1367.01(h)(4). The audit tool has been included in the Plan's response for the Department's review [Attachment 1_UM_Audit Tool Denial]. The Plan's internal workgroup uses an Industry Collaboration Effort (ICE) template and desktop procedure [Attachment 1_ICE_Medi-Cal_Denial_Reason_Matrix, 1_UM Denial Letter Process] as additional tools to provide clear and understandable language specific to a denial/modification situation and in language at the required sixth (6th) grade reading level. As noted in the Plan's Utilization Management	1_UM Denial Letter Process 1_UM_Audit Tool Denial 1_UM_ICE_Medi-Cal_Denial_Reason_Matrix 1_UM_UMC Meeting Minutes_05-25-2017	February 10, 2017 March 1, 2017 N/A N/A	process to conduct random routine audits on a minimum of 5 NOAs per month. The audit tool requires the reviewer to assess whether the NOA contains clear and understandable language. - "ICE Medi-Cal Pre-Service Denial and Modification Reason Matrix "(12/18/17) which provides guidance to staff on simple (6th grade reading level) denial language to use for specific scenarios. - "Utilization Management Committee Meeting Minutes" (05/25/17) as evidence that the plan continues to discuss the ongoing need for continued education and training to ensure appropriate member-friendly language in its NOAs (page 5). - "Denial File Review Challenges" (August 2017) and "UM Denial and Appeal File Review Exercise" (August 2017) as evidence that plan staff received training on how to develop NOAs in an easy to

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	Committee (UMC) meeting minutes dated May 25, 2017, [Attachment: 1_UM_UMC Meeting Minutes_05-25-2017], in the "Denial Letter Process" section on page 5, the Plan and its delegated entities have continuously engaged in discussion focused on appropriate member-friendly language in NOA letters. In addition, on August 16, 2017, the Plan and its delegated entities participated in a collaborative workshop [Attachments: 1_Denial File Review Challenges PPT and 1_Denial Appeal Exercise With Answers], which discussed best practices and case scenarios for communicating Plan actions and decisions in clear and understandable language. <u>Pharmacy Response</u> 1) In response to the identified deficiency, the Plan's Pharmacy Management department has developed and implemented a Pharmacy Denial Matrix [Attachment 1_Pharmacy_Denial	<u>Pharmacy Documents</u>: 1_Pharmacy_Denial Matrix 1_Pharmacy_Team Meeting_Denial Reasons_Criteria_08-17-2017	October 23, 2017 August 17, 2017	understand language for the member. **<u>Pharmacy</u>** - "Pharmacy Denial Matrix" (12/18/17) as evidence that MCP provides guidance to staff on simple (6th grade reading level) denial language to use for specific scenarios. - "MCAL Clinical Pharmacist Meeting Agenda" (08/17/17) as evidence that the plan developed training to pharmacy staff to ensure that they write NOAs in a clear and easy to understand language. - PBM checklist (implemented on 09/19/17) as evidence that MCP's PBM additionally conducts audits to ensure that rationale langue is clear and concise. - "Pharmacy PA Appeal Audit" (12/18/17) to indicate that the plan's pharmacy department is conducting random routine audits on their NOAs to check that it is developed in in a 6th grade reading level.

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	Matrix] to ensure Notice of Action (NOA) and Notice of Appeal Resolution (NAR) letters contain standardized language at the appropriate 6th grade reading level. The matrix includes, among other elements, standardized template language for denial rationale and the letter templates to which this matrix applies. 2) In response to the identified deficiency, the Plan's Pharmacy Management department conducted a training to Pharmacy Management staff on 8/17/17 [Attachment: 1_Team Meeting_Denial Reasons_Criteria_08-17-2017] to ensure staff is aware of the clear and understandable language that must be included in NOA letters issued by the Plan's Pharmacy Management staff. 3) As a quality review, the Plan's Pharmacy Management department performs monthly audits of at least thirty (30) denial prior authorizations (PAs) and eight (8) appeal upheld cases utilizing a department-specific	1_Pharmacy_Pharmacy PA & Appeal Audit 1_Pharmacy_PBM QA of NOAs 1_Pharmacy_DTP_MCAL Monthly Pharmacist Audit	April 2017 September 19, 2017 November 8, 2017	**This finding is closed.**

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	audit tool [Attachment: 1_Pharmacy PA & Appeal Audit]. As part of this process, NOAs are reviewed to ensure the NOA language reads at a 6th grade reading level as outlined in the Plan's Pharmacy Management desktop procedure [Attachment 1_Pharmacy_DTP_MCAL Monthly Pharmacist Audit]. Findings discovered during the monthly audit are addressed with individual staff for coaching and retraining. 4) In addition, the Plan is requiring the Pharmacy Benefit Manager (PBM) to review NOA letters for ease of understanding prior to sending these letters to members. The PBM's review process is attached for the Department's reference [Attachment 1_Pharmacy_PBM QA of NOAs]. <u>Audit & Oversight (A&O) Response</u> The Plan's Audit & Oversight (A&O) Department maintains	<u>A&O Documents:</u> 1_A&O_UM_AuditTool_Routine_Auth 1_A&O_UM_AuditTool_Routine_Denial 1_A&O_UM_AuditTool_Standar	A&O Implementation Implemented in 2014.	

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	oversight of this regulatory requirement on a monthly basis utilizing internal audit tools to review authorizations processed by the Plan and its delegated health networks. Among other sections, each clinical auditor utilizes the "Letter/Language Template" section of their internal audit tools [Attachments: 1_A&O_UM_AuditTool_Routine_ Auth 1_A&O_UM_AuditTool_Routine_ Denial and 1_A&O_UM_AuditTool_Standard Organization Determination] to assess and validate that the Plan and all delegated entities are providing actions and decisions in a clear and understandable language to the Plan's members in accordance with CA Health and Safety Code Section 1367.01(h)(4). If the Plan or any delegated entity does not comply with this requirement, a Corrective Action Plan (CAP) is issued in accordance with CalOptima Policy HH.2005: Corrective Action Plan.	d Organization Determination 1_Pharmacy PA & Appeal Audit	January 5, 2018	

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	<u>1/9/2018 – Follow up</u> The Plan appreciates the opportunity to address the request for additional information, made on 12/28/17, by DHCS. The request and responses are as follows: 1. Similar to the medical side, we're mainly looking to confirm that the Pharmacy audit also specifically assesses whether the NOA was clear and concise. Can you please send us any supporting documentation to show this? ▪ The Plan's Pharmacy Management department updated the Pharmacy PA & Appeal Audit tool [Attachment: 1_Pharmacy PA & Appeal Audit], to better document the assessment and validation that is conducted for all denial prior authorizations (PAs) and appeal upheld cases reviewed, on a monthly basis, to ensure they include clear and			

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	concise language in the Notice of Action (NOA) rationale. 2. In the attached Pharmacy PA & Appeal Audit, can you please tell us what "SMOG" stands for? ▪ The Plan notes that SMOG stands for "Simple Measure of Gobbledygook." The SMOG grade is a measure of readability that estimates the years of education needed to understand a piece of writing			
2. Case Management and Coordination of Care				
2.2.1. The Plan did not ensure the coordination of services and joint case management between its Primary Care Providers, the CCS specialty providers, and the local CCS program to avoid delay in	In response to the identified deficiency, the Plan will update the Plan's Audit & Oversight (A&O) annual audit tool [Attachment: 2_ CalOptima_2017 Medi-Cal Addendum Annual Audit Tool_11-09-2017] to assess and validate that all of the Plan's delegated entities are properly identifying the Primary Care Provider (PCP) and the Plan's	2_CalOptima_2017 Medi-Cal Addendum Annual Audit Tool_11-09-2017	January 1, 2018	**12/18/17** – The following documentation supports the MCP's efforts to correct this finding: - "2017 Readiness/ Annual Assessment: Medi-Cal Addendum Tool" (11/09/17) which MCP utilizes on annual basis to audit all delegates. Page 3 of the audit tool (Element D.8) requires the auditor to audit 10 files to assess consistency

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providing services to the Members.	listed Medical Home team for efficient coordination of services and case management of its Members as outlined on line items 27–48. The Plan will review a random sample of ten (10) CCS Service Authorization Requests (SARs) on a quarterly basis to monitor for consistency with actions developed to address identified discrepancies. The Plan will discuss the results of their reviews at monthly collaborative meetings, which include CCS, Regional Center of Orange County (RCOC) and Plan staff. The Plan has dedicated staff who will serve as a CCS liaison and assist CCS staff with resolution of Medical Home/ PCP discrepancies, which will be reiterated at next quarterly CCS/RCOC/Plan collaborative meeting. All actions outlined above by the Plan will have an effective date of January 1, 2018. <u>1/10/2018 – Follow up</u>			between the CCS medical home and plan PCP. **01/10/18 –** The following additional documentation submitted supports the MCP's efforts to correct this deficiency: - MCP's written response additionally clarifies that the plan begun conducting quarterly reviews of 10 sample cases to ensure consistency between the PCP and Medical Home during the 4th quarter of 2017. The MCP discussed results of its monitoring at the CCS/CalOptima/RCOC Quarterly meeting on 11/07/17. -Corresponding meeting minutes from the CCS/CalOptima/RCOC meeting (11/07/17) as evidence that MCP had discussed results of Q4 2017 audit. Of the 10 cases reviewed, there was 1 case where the PCP did not match the medical home. MCP discussed the reasons for this discrepancy and follow-up action taken.

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	The Plan appreciates the opportunity to address the request for additional information, made on 12/21/17, by DHCS. The request and responses are as follows: 1. Please review the attached Annual Audit tool and see the inserted comment (page 2). While we see that the plan is conducting an annual audit of its delegates, we're not quite sure whether this specific action addresses the nature of this finding specifically. ▪ The Plan respectfully brings your attention to page 3 of the Medi-Cal Addendum Audit Tool, initially submitted on 12/18/17. The Plan incorporated this specific question (MED3, Element D, item #8) to the audit tool and has bookmarked it in the attached [Attachment 2_CalOptima_2017 Medi-Cal Addendum Annual	2_CalOptima_2017 Medi-Cal Addendum Annual Audit Tool_11-09-2017 2_RCOC_CCS_CalOptima_Meeting Minutes	January 1, 2018 November 7, 2017	**This finding is closed.**

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	Audit Tool_11-09-2017] for ease of finding. 2. We like the idea of conducting quarterly reviews where 10 sample cases will be reviewed to ensure consistency between the PCP and Medical Home. But can the plan please clarify when the first quarter results will be completed? We're assuming the first quarter commences 1/1/18 so the raw data may not be compiled until the end of Q1. ▪ The Plan implemented this change assoon as it became aware. The first review was completed during the fourth quarter of 2017. The Plan discussed the results of its monitoring and reasons for discrepancies at the CCS/CalOptima/RCOC Quarterly Meeting on November 7, 2017 [Attachment 2_RCOC_CCS_CalOptima_Meeting Minutes].			

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	3. Can you provide us with the anticipated date of the next quarterly CCS/RCOC/Plan collaborative meeting where PCP/Medical Home discrepancies will be discussed? ▪ The next meeting is scheduled for January 23, 2018. 4. Overall, we are really just looking to see that the plan has processes in place to continually ensure that the information (PCP/Health Home) in the plan's system is consistent with the information included on the SARs and with the information in CCS' system. ▪ The Plan has a collaborative plan with CCS and feel it will address the concerns.			

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2.4.1. The Plan does not specify the requirements to the PCP for appropriately documenting SHA refusal by the Member	The Plan updated policy GG.1203: Individual Health Education Behavioral Assessments (IHEBA) by adding language to sections II.D.1 and III.A.15 [Attachment: 3_GG.1203_IHEBA to incorporate additional language in response to the identified finding. These changes were approved by the Plan's internal Policy Review Committee on October 10, 2017, and will be finalized by the Plan's Chief Executive Officer following DHCS review and approval of the changes. The Plan updated Section M3: Initial Health Assessment of the Plan's Provider Manual [Attachment: 3_Section M3- IHA] to incorporate additional language in response to the identified findings. Lastly, the Plan updated the Facility Site Review (FSR) tool [Attachment: 3_DHCS 2014 FSR-MRR Full Scope Audit_SHA] to incorporate the SHA refusal	3_GG.1203_IHEBA 3_Section M3-IHA 3_DHCS 2014 FSR- MRR Full Scope Audit_SHA	Retroactive implementation to October 1, 2017; pending DHCS approval. December 20, 2017 November 8, 2017	**12/18/17** - The following documentation supports the MCP's efforts to correct this finding: - Policy GG.1203 IHEBA was updated (10/01/17) to include PCP requirements for documenting a member's refusal to complete the SHA. The addition of language in Section III.15 requires the PCP to document all four bulleted elements consistent with PL-13-001 (e.g., entering in the member's name, checking the "SHA Declined by Patient" box, etc.). - Revised Provider Manual excerpt (Section M3: Initial Health Assessment) was updated to include language to direct providers to document any SHA refusal on the SHA questionnaire. - Revised FSR Tool which has been updated to include a question to assess and monitor whether or not the member's refusal to complete SHA was properly documented for both adults and children (Section IV

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	component, which is highlighted in line item #139 of the MRR Tool tab.			– Pediatric, line item 139; Section V – Adult; line item 223). **This finding is closed.**
4. Members' Rights				
4.3.1. The Plan did not report notifications of breach incidents and investigations of breaches in timely manner	The Plan failed to report seventeen breach incidents in a timely manner due to the former CalOptima Privacy Officer and former CalOptima Privacy Manager's non-adherence to the Plan's policies and procedures for reporting privacy and security incidents. Both individuals were separated from the Plan in February 2016. A new Privacy Officer and Privacy Manager were hired, respectively in March and May of 2016. The new Privacy Officer and Privacy Manager were trained on CalOptima's policies and procedures and contractual requirements during their on-boarding. The Plan implemented a "HIPAA Incident Tracking Log" [Attachment: 4_HIPAA Incident	4_HIPAA Incident Tracking Log 4_What's Due Report 4_Revised DTP HIPAA Breach Reporting Training 4_Revised DTP HIPAA Breach 11.8.16 (Redlined) 4_Revised DTP HIPAA Breach 11.8.16 (Clean)]	June 1, 2016 January 1, 2017 November 17, 2016 November 8, 2016 November 8, 2016	**12/18/17** – The following documentation supports the MCP's efforts to correct this finding: - Draft (redlined) version of "Desktop Procedure for HIPAA Breaches or Security Incidents" (revised 11/08/16). The desktop procedure delineates reporting to DHCS at each of the three required ***intervals*** (i.e., 24hrs, 72hrs, and 10 working days). DHCS provided feedback to MCP to additionally incorporate language to require reporting to each of the three required ***entities*** for each of the required intervals as well. (The DTP currently only shows reporting to the Privacy Officer at the 24hr junction and does not include the Contract Manager or Information Security Officer.)

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	Tracking Log] in June 2016 which enabled the Privacy Officer and Privacy Manager to monitor the timeliness of the submitted initial, interim and final breach incident reports. In January 2017, the Plan replaced the HIPAA Incident Tracking Log and implemented a new database which tracks initial, interim and final breach incident reports. The new database has increased reporting functionality and enables both the Privacy Officer and the Privacy Analysts to run a report [Attachment:4_What's Due Report] of due dates and case progress. In addition to the monitoring tools the Plan implemented, the Plan also added two Privacy Analyst staff members to the HIPAA Privacy Department in November 2016. The additional staff not only assists with ensuring the Plan remains compliant with the reporting requirements and timeframes but also enables the Plan to conduct more proactive			- Sample "What's Due Report" as evidence that the MCP has fully implemented its new database which has the capability of generating reports to identify reports that are due for each of the three distinct reporting timeframes (initial – 24hrs; interim/update – 72hrs; final – 10 working days). **01/10/18** – The following additional documentation supports the MCP's subsequent efforts to correct this finding: **Revised P&P** - Revised draft (redlined) version of "Desktop Procedure for HIPAA Breaches or Security Incidents" (revised 12/29/17). Section lll.F.1 delineates reporting of HIPPA breaches to the three required entities at each of the required intervals (immediate phone call, within 24hrs, 72hrs and 10 working days). **Staff Training** - A written communication (a copy of the e-mail message) between MCP's

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	training and awareness activities. On November 17, 2016 the Privacy Analysts received training on department procedures (i.e. desktop procedures) and are aware of CalOptima's policies and procedures and contractual requirements for reporting privacy and security incidents. [Attachments: 4_Revised DTP HIPAA Breach Reporting Training, 4_Revised DTP HIPAA Breach 11.8.16 Redlined, 4_Revised DTP HIPAA Breach 11.8.16 Clean]. Furthermore, the Plan also created a designated Privacy Officer position in February 2017 which was assumed by the CalOptima Privacy Manager. The Privacy Officer duties had historically been an additional responsibility of a Regulatory Affairs and Compliance Director. The creation of a position dedicated solely to HIPAA Privacy demonstrates the Plan's continued efforts to achieve compliance with federal, state and			Privacy Officer and MCP staff conveying the updates made to the DTP. The email indicates training occurred on 01/09/18 and these revisions were discussed. **<u>Monitoring Efforts</u>** - MCP's written response (email 01/10/18) describes how the MCP's new database allows for increased monitoring and oversight through the generation of custom reports where various data elements can be tracked. The "What's Due" report specifically allows the MCP to track deadlines for reporting to DHCS from the date of discovery. Beginning January 2018, the Privacy Department will begin conducting monthly internal monitoring. Monitoring will consist of pulling a random sample of 50% of all referrals at the beginning of each month. Cases will be reviewed to assess whether notifications were sent to all three DHCS contacts at the required intervals.

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	contractual obligations in reporting and investigating breach incidents. <u>1/10/2018 – Follow up</u> ▪ The Plan has revised the DTP based on the reviewer's comments [Attachment 4_Revised DTP HIPAA Breach_Redline]. A copy of the revised DTP was reviewed with CalOptima's Privacy staff on January 9, 2018 [Attachment: 4_Staff Training on Updated DTP]. ▪ The new database allows for increased monitoring and oversight through custom reports. Currently, the reports that can be generated and the data they track are as follows: - **Compliance Committee** - **Open Analyst Report** - **What's Due** **- Open Summary Report** - **Privacy Universe**	4_Revised DTP HIPAA Breach_Redline 4_Staff Training on Updated DTP 4_HIPAA Incident Monitoring Log		- Sample "HIPPA Incident Monitoring Log" as evidence that MCP has developed the tracking tool that will be used for its monthly audits. The log requires the review to document compliance with reporting of breaches to the three entities at each of the required intervals (24hrs, 72hrs, and 10 working days). **This finding is closed.**

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	▪ The Plan's Privacy department monitors its referrals to DHCS in several ways. First, CalOptima's Privacy staff copy its Privacy Officer and Compliance Officer on all referrals to DHCS. The Plan's DTP has been revised to reflect this directive [Attachment 4_Revised DTP HIPAA Breach_Redline]. As such, CalOptima management has ongoing visibility into the referrals to ensure that all referrals are sent to the DHCS Privacy Officer, ISO and Contract Manager. It should be noted that the plan did not receive an audit finding related to non-compliance with this requirement during the 2017 DHCS Medi-Cal audit. Therefore, the plan believes the current process is adequately working.			

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	Additionally, beginning January 2018 the CalOptima Privacy department will begin conducting monthly internal monitoring of its privacy investigation referrals. Internal monitoring will be conducted on the first business day of each month for the prior month's referrals. Monthly internal monitoring will consist of a review of a random sample of 50% of all referrals per month to ensure that notifications are sent to all three of the DHCS contacts (i.e., Contract Manager, Privacy Officer, Information Security Officer), as well as to ensure timely reporting for each of the three distinct reporting junctions (initial – 24hrs; interim – 72hrs; final – 10 working days) [Attachment 4_HIPAA			

Submitted by: CEO Signature on File **Date:** 12/18/17
Title: CEO