ATTACHMENT A
Corrective Action Plan Response Form

Plan Name: Central California Alliance for Health

Review/Audit Type: Medical Review **Review Period: June 1, 2013 through May 31, 2014**

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.

CORRECTIVE ACTION PLAN FORMAT

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
1. Utilization Management				
1.1.1 The MCP must ensure the application of medical decision making criteria, including Medi-Cal guidelines when reviewing prior authorization decisions.	The Alliance ensures that Medi-Cal guidelines are consistently applied to ensure that medically necessary Medi-Cal covered services are not denied. The Utilization Management (UM) Director has met with Prior Authorization staff (03/17/2015) and the Alliance Medical Directors (03/24/2015) to confirm their understanding that Medi-Cal	1.1.1 – Medical Director Group Meeting Minutes 03/24/2015 1.1.1 – Prior Authorization Meeting Minutes 03/17/2015	Staff training: 03/24/2015 Policy revisions: 05/06/2015	4/24/15; Meeting minutes from Medical Director Group indicate discussion of Medi-Cal criteria and its application during prior authorization decision making. Meeting minutes from UM Prior Authorization indicates a discussion regarding Medi-Cal guidelines are followed when determining medical necessity. Alliance utilization criteria are being updated indicating Medi-Cal guidelines are

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	guidelines must consistently be applied when reviewing prior authorization decisions. Alliance Policy # 404-1101 - Utilization Management Program has been revised to clearly state that Medi-Cal decision-making criteria will be consistently applied.	1.1.1 – Policy #404-1101 – Utilization Management Program		prioritized over all other decision making guidelines. Submission of revised Policy #404-1101which indicates use of Medi-Cal guidelines (when available) for authorization decisions and as well as revised review criteria based on sound clinical evidence. Review/approval of the policy expected by 5/6/15. 5/13/15; Policy #404-1101 has been reviewed and is hereby approved with respect to the medical audit. This deficiency is closed. 6/25/15; Note Alliance utilization criteria has been updated to reflect Medi-Cal guidelines are to be prioritized over all other decision-making guidelines so that Medi-Cal covered services are not denied. As noted in the audit report, only one appeal was affected. Follow up will be conducted at the next medical audit to ensure Medi-Cal guidelines are being consistently applied when reviewing prior authorization decisions. This deficiency is closed.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
1.1.2 The MCP must modify current language contained in their EOC to accurately reflect the contract requirements and applicable regulations pertaining to payment of out-of-state ER services.	The Alliance has modified the language in the Member Evidence of Coverage (EOC) on page 59 to state that if a member receives emergency services outside of California and receives a bill, the member should contact the Alliance and Alliance staff will work with the hospital to try to get them to submit a claim.	1.1.2 – Member Handbook – Evidence of Coverage	04/16/2015	4/24/15; EOC language is not consistent with the contract, California Health & Safety Code 1317, and/or 42 CFR 438.114 Member Handbook has been revised to be consistent with contractual requirements when a member received emergency services outside California. This deficiency is closed.
1.2.1 The MCP must adhere to contractual and statutory time frames with regard to pharmacy prior authorizations which require 24-hour turnaround time.	The Alliance has updated its Pharmacy Prior Authorization process to make determinations within 24-hours or next business day from receipt of authorization request. Alliance Policy #403-1103 Pharmacy Authorization Request Review Process has been revised to incorporate the new process, with an effective date of 08/01/2015. The revised policy will be implemented after noticing the provider network, and published in the revised Provider Manual with the same effective date.	1.2.1 – Policy #403-1103 – Pharmacy Authorization Request Review Process	04/15/2015	10/22 pharmacy prior authorizations reviewed were delayed greater than one business day in violation of the contract and W&I Code 14185(a). 4/27/15; The Alliance submitted a revised Policy #403-1103 that reflects determinations on all requests for pharmaceuticals that require prior authorization…are made within 24 hours or one business day in accordance with W&I Code. New P&P will go in effect upon notice to provide network effective 8/1/15. 5/13/15; Policy #403-1103 has been reviewed. MCQMD recently issued a policy clarification regarding timeframes for responding to pharmaceutical prior authorizations. Response includes approval, denial or request for more information. Once the Alliance has the

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				information to make a decision, they must do so within 24 hours or 1 business day (decision can only be approval or denial). 8/4/15; MCQMD is re-categorizing this deficiency as provisionally closed. The Alliance has revised its policies to reflect contractual requirements and implementation of revised policy will go into effect 8/1/15. MCQMD will follow up with the Alliance regarding progress being made with adhering to the required timeframes regarding pharmaceutical prior authorization requests.
1.2.2 The MCP must clarify policies and procedures regarding out of network and out of service area referrals.	The Alliance has updated its policies and procedures to ensure consistency regarding out of network and out of service area referrals.	1.2.2 – Policy #404-1201 – Authorization Request Process 1.2.2 – Policy #404-1310 – Out of Service Area Referrals	Policy #404-1201 revised: 12/10/2014, DHCS approval: 01/08/2015 Policy #404-1310 revised: 09/17/2014, DHCS approval: 12/23/2014	Affected Policies and Procedures are #404-1310 and #404-1201. 4/27/15; The Alliance appears to still have conflicting policies with regards to referrals for non-contracted providers. Refer to Summary of Findings under 1.2. The Alliance is requested to provider further clarification of action taken to ensure consistency of network and out of service area referrals. 5/28/15; The Alliance submitted revised policies and procedures clarifying procedures (prior authorization requirements) for out-of-network/in-service area referrals. This deficiency is closed.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
1.2.3 The MCP must ensure Policy #404-1201 accurately reflects the behavioral health benefit and corrects policies with regards to the grievance and appeals process.	The Alliance has revised Policy #404-1201 – Authorization Request Process to accurately reflect the behavioral health benefit and the updated grievance and appeals policies.	1.2.2 – Policy #404-1201 – Authorization Request Process	Policy revised: 12/10/2014, DHCS approval: 01/08/2015	Policy #404-1201 refers to behavioral health as a carve out service and cites non-existent grievance and appeals policies. 4/27/15; Policy #404-1201 has been revised to reflect the behavioral health benefit. DHCS has already approved the revised policy. Citations to non-existent grievance and appeals policies have been removed. Notes member's grievance and appeals rights by noting Policy #105-1002 Member Grievance System. This deficiency is closed.
1.2.4 The MCP must ensure NOA letters are sent whenever a service is denied or modified and that such letters are sent timely (no later than the third business day after the action or determination.)	As noted in the audit findings, this finding involves only one file out of those reviewed. Although this deficiency is closed, the Alliance took steps to further ensure compliance with existing policy and procedure, as follows. The Alliance has implemented a process to monitor its performance and compliance with Notice of Action (NOA) letters to ensure that timeliness requirements are met. This is achieved by reviewing daily correspondence reports for timeliness and process completion. Compliance with this		04/01/2015	The verification study found one file with this deficiency. The Alliance is encouraged to take the necessary steps to ensure NOA letters are sent timely. This deficiency is closed. 4/27/15; Note the Alliance has taken additional steps to ensure to ensure timeliness requirements are met – review of daily correspondence reports for timeliness and process completion, as well as, increase prior authorization staff. 6/25/15; While this deficiency remains closed, in an order to verify implementation, MCQMD requests the Alliance to submit a copy of the report (timeliness and process completion) that is

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	process is reported through the Alliance's Administrative Quality Indicator (AQI) process, and is reported quarterly to the Board. Additionally, Prior Authorization staff has been increased to ensure compliance with the NOA timeliness requirements.			submitted quarterly to the Board. 8/11/15; The Alliance submitted their Administrative Quality Indicator Exception Report for the first quarter of 2015 in which non-pharmacy prior authorization request denial letters were sent within 3 business days of the decision. For the first quarter, 98% of denial letters were sent to members within two days of determination. One delay was due to technical issues involving translation and three delays were due to staff scheduling issues.
1.3.1 The MCP must develop and implement a process to track open and unused referrals requiring prior authorization.	The Alliance will develop a process to track open or unused referrals requiring prior authorization. These referrals will be tracked and reported to the UM Committee (UMC) for review at least annually. Furthermore, unused referral reports will be made available to the requesting provider.		06/30/2015	The Alliance is required to track and monitor services requiring prior authorization…including authorized, denied, deferred, or modified prior authorizations. 4/27/15; The Alliance is developing a process to track open and unused referrals requiring prior authorization. The Alliance will report to UM Committee for review annually and unused reports will be made available to requesting providers. Expected completion/implementation date: 6/30/15. 5/13/15; Requested Alliance to submit preliminary documentation of process being developed to track open and unused referrals requiring prior authorization. If/when the Alliance can demonstrate they are moving

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				forward addressing this deficiency, the provisional closure will be deemed closed. 6/22/15; The Alliance is requesting technical assistance as they work toward finalizing a methodology for monitoring the PCP referral tracking process. Advised the Alliance to submit what they have for review/comment. 7/6/15; The Alliance has developed a "Referrals Report" that identifies authorized referrals that do not have associated claims. These open and unused referrals requiring prior authorization are then filtered by provider and shared with the requesting provider via the provider portal. These reports will be tracked and reviewed by the Alliance's UM Committee at least annually. The Alliance submitted a copy of the Referrals Report along with a copy of the provider notice. This deficiency is provisionally closed. MCQMD notes that expected implementation is 6/30/15. MCQMD will follow up with the Alliance to verify process to track open and unused referrals has been implemented.
1.3.2 The MCP must monitor PCPs' referral tracking process for referrals requiring prior authorization.	The Alliance will develop a process to monitor PCP's referral tracking process for referrals requiring prior authorization.		06/30/2015	NOTE: As indicated in the audit report, the Alliance tracks timeliness of referral authorization and delegates the tracking of prior authorization referrals to completion to their PCPs. The tracking of open and unused referrals

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				requiring prior authorization needs to be added to the MCP's tracking process. This deficiency remains open. In order to receive a provisional closure, the Alliance will need to submit a framework of its policy and procedure for monitoring PCP referral tracking process. 6/22/15; See comment noted in 1.3.1 7/6/15; The Alliance has developed a "Referrals Report" that identifies authorized referrals that do not have associated claims. These open and unused referrals requiring prior authorization are then filtered by provider and shared with the requesting provider via the provider portal. This portal allows providers to review open and unused referrals for their linked members. Providers are encouraged to follow up with members to make sure follow up care is being completed. These reports will be tracked and reviewed by the Alliance's UM Committee at least annually. The Alliance submitted a copy of the Referrals Report along with a copy of the provider notice. This deficiency is provisionally closed. Follow up will be conducted at the next medical audit to ensure the Alliance has implemented these new processes and that the PCP's referral tracking

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				process is being monitored.
1.4.1 The MCP must ensure all appeals are reviewed by a physician per contractual requirements.	The Alliance's policy and procedure requires review of all appeals by an Alliance Medical Director. As noted in the audit findings, this deficiency involves one file out of those reviewed. To further ensure compliance with existing policy and procedure, Alliance staff has been retrained to ensure Medical Director review is documented by the reviewing Medical Director in the Alliance Care Tracking System (ACT) Grievance record. In addition, Grievance Supervisors will be auditing cases to ensure compliance with contractual requirements.		01/29/2015	This deficiency involves one file. Suggest the Alliance add a quality control step to ensure consistent physician review of appeals. 4/27/15; Note the Alliance retrained staff to ensure compliance with existing policy – that ensure Medical Director reviews are documented in the grievance records. Grievance supervisors will also audit cases to ensure compliance with contractual requirements. This deficiency is closed.
1.4.2 The MCP must ensure all grievance and appeal acknowledgement letters are sent out within the required 5-day timeframe.	As noted in the audit findings, this deficiency involves only one file out of those reviewed. Although this deficiency is closed, the Alliance took steps to further ensure compliance with existing policy and procedure, as		01/29/2015	This deficiency involves one file. The Alliance is encouraged to take the necessary steps to ensure acknowledgement letters are sent timely. 4/27/15; Note the Alliance reinforced the importance of the requirement that

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	follows. The Alliance reinforced the importance of this requirement with staff to ensure all appeal acknowledgement letters are sent out within the required five day time frame.			acknowledgement letters are required to be sent within five days. This deficiency is closed.
1.4.3 The MCP must ensure all resolution letters are sent within the required 30-day timeframe, and if not, a Notice of Unresolved Complaint Letter is sent to the member.	As noted in the audit findings, this deficiency involves only one file out of those reviewed. Although this deficiency is closed, the Alliance took steps to further ensure compliance with existing policy and procedure, as follows. The Alliance reinforced the importance of this requirement with staff to ensure all appeal resolution letters are sent within the required 30-day time frame, and if not, that a *Notice of Unresolved Complaint Letter* is sent to the Member.		01/29/2015	This deficiency involves one file. The Alliance is encouraged to take the necessary steps to ensure all resolution letters are sent timely. 4/27/15; Note the Alliance reinforced the importance of the requirement that resolution letters are sent to members within the required timeframe and if not, a Notice of Unresolved Complaint Letter is sent to the member. This deficiency is closed.
1.5.1 Ensure Compliance Committee approval is obtained prior to delegation of UM activities.	The Alliance will ensure that Compliance Committee approval is obtained prior to the delegation of future UM activities. Adherence to the existing delegated oversight requirement was reiterated during the April 15, 2015 Compliance Committee meeting.		04/15/2015	The Alliance recommended updating delegation oversight process to ensure pre-delegation audits are performed and approved prior to delegation of UM activities. 4/28/15; Note that the Alliance has a delegation oversight process in place and pre-delegation and annual oversight audits were/are performed. In the case of Beacon, delegation approval resulted

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	The Alliance notes that its use of Beacon-CHIPA in January 2014, prior to Compliance Committee's approval of the entity, was a result of the very short timeframe provided to implement the new mental health benefit for Medi-Cal members. The Alliance began providing services on 01/01/2014 through a letter of agreement with Beacon-CHIPA, in order to meet members' needs for mental health services, as required by DHCS. All departmental subject matter experts reviewed and recommended Beacon for approval through a documented pre-delegation assessment by 01/24/2014. However, Compliance Committee approval of the document was not obtained until 04/15/2014. The contract with Beacon-CHIPA was not executed until 06/11/2014, after Compliance Committee approval of delegation.			from short timeframe provided to implement the new mental health benefit. The Alliance will ensure Compliance Committee approval is obtained in the future prior to delegation of UM activities. This deficiency is closed.
1.5.2 Ensure all issues relating to pre-delegation audits are addressed prior to approving delegation.	The Alliance will ensure all issues on the pre-delegation audit for a delegated entity are resolved prior to approving delegation.		4/15/2015	The Alliance recommended to update delegation oversight process to ensure pre-delegation audits are performed and unresolved issues are addressed prior to approval of UM activities. 4/28/15; The Alliance will ensure all future pre-delegation audit issues are addressed and documented.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				This deficiency is closed.
1.5.3 Policy #404-1201 needs to be updated to reflect UM delegation oversight is now done by the Compliance Committee.	Alliance Policy #404-1201 Authorization Request Process was revised on 09/03/2014 to reflect the Compliance Committee's oversight of delegation activities.	1.2.2 – Policy #404-1201 – Authorization Request Process	09/03/2014	4/28/15; Policy #404-1201 has been revised to reflect the Compliance Committee reviews quarterly and approved both quarterly and annually by the Compliance Committee. This deficiency is closed.
2. Case Management and Coordination of Care				
2.1.2 MCP must ensure primary care providers are educated regarding the structure and function of contractually required Complex Case Management services for Members and how these services are accessed.	The Alliance developed the following to address continued provider education regarding Complex Case Management services: - The new provider training agenda (checklist) and presentation has been updated to include an overview of Care Management Complex Case Management Services. It is now a required training component for all new PCPs. The updated training was implemented in March 2015.	2.1.2 – New Provider Training Agenda	03/04/2015	NOTE: PCPs reported several specialty providers and services were difficult to access and members waited months for appointments. PCPs also cited the need for increased access to several different types of specialists. These issues are being addressed in Deficiency 5.1 Quality and 3.1 Access. 4/28/15; MCQMD notes the inclusion of Care Management in the revised new provider training agenda. Note proposed expanded section on care management in the Provider Manual including information on complex case management.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	- The Care Management section (Section 8) in the Provider Manual is being expanded, including information on complex case management services, which will be available to providers on 08/01/2015.		05/27/2015	Note proposed letter to be mailed to all PCPs providing information on the Alliance's Care Management Program. Note provider section of website has been updated with expanded Care Management resources. Note proposed Care Management presentations highlighting key components and benefits of the care management program will be completed by end of August. 5/13/15; Requested Alliance to submit preliminary documentation of proposed Care Management Presentation being developed addressing key components and benefits of the care management program. When the Alliance can demonstrate they are moving forward addressing this deficiency, the provisional closure will be deemed closed. 6/26/15; Alliance submitted an overview of their Care Management Video presentation on complex case management. The website has been updated/expanded with Care Management Program resources. Presentations are ongoing and will be completed by 8/31/15. This deficiency is closed.
	- The Care Management Department will mail all PCPs an information letter regarding the Alliance's Care Management Program on 06/01/2015.		06/01/2015	
	- The provider section of the Alliance's website will be updated with expanded Care Management Program resources by 04/30/2015.		04/30/2015	
	The Alliance Care Management Department will begin conducting presentations throughout its service area to highlight key components and benefits of the Care Management Program. Provider sites have been selected and presentations will be completed by 08/31/2015.		08/31/2015	

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
2.1.3 MCP must ensure policies and procedures describe contractually required Complex Case Management services and the roles of multi-disciplinary participants including primary care providers and appropriately licensed nurses.	The Alliance has revised Policy #405-1113 – Complex Case Management, and Policy #404-1313 – PCP Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home, to include language regarding Complex Case Management services and the roles of the multidisciplinary team members.	2.1.3 – Policy #405-1113 Complex Case Management 2.1.3 – Policy #404-1313 – PCP Responsibility Including Case Management and the Promotion of Patient Centered Medical Home	Policy #405-1113 revised: 04/15/2015 Policy #404-1313 revisions: 05/06/2015	Affected Policy and Procedures are #404-1313 and #405-1113. Roles of PCPs and registered nurses and licensed vocational nurses need to be clarified. 4/28/15; The Alliance submitted revised Policy #405-1113 which describes Complex Case Management and care coordination in collaboration with a PCP and a multidisciplinary team. Policy #404-1313 has also been revised – the policy describes the process and responsibilities of the PCP with regard to case management responsibilities. It explains case and complex case management and the PCP's responsibilities for both in collaboration with the Alliance. This deficiency is provisionally closed pending DHCS approval of Policies #405-1113 and #404-1313. 5/13/15; Revised Policy #404-1313 and Policy #405-1113. Both policies have been reviewed and are hereby approved with respect to the medical audit. This deficiency is closed.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
2.3.1 MCP must ensure the MOUs between the MCP and the Regional Centers are fully executed.	The Alliance continues to convene regular meetings with the Regional Centers and has begun documenting the meetings with meeting minutes. Meetings between the Alliance and the Regional Centers occurred in 2014 and 2015, as described below, and are scheduled to occur at least quarterly. - Meetings between the Alliance and the Central Valley Regional Center (CVRC) occurred on 12/08/2014, 01/05/2015, 02/02/2015, and 03/24/2015. - The MOU between the Alliance and the CVRC was reviewed on 03/24/2015. - Meetings between the Alliance and the San Andreas Regional Center (SARC) occurred on 10/29/2014, 12/04/2014, 01/07/2015, 02/04/2015, 03/04/2015. - The MOU between the Alliance and the SARC was reviewed on 03/04/2015.	2.3.1 - CVRC Meeting Agendas, Minutes, and Notes 2.3.1 - SARC Meeting Agendas, Minutes, and Notes	CVRC MOU reviewed: 03/24/2015 SARC MOU reviewed: 03/04/2015	The MCP has two MOUs with local Regional Centers for coordination of services. One MOU required annual review and the other required review/revision as needed. Both were last updated in 2009. MCP is to meet with the Regional Centers semi-annually and annually to resolve issues and ensure ongoing communication. The MCP could not provide meeting minutes to document communication on a semi-annual and annual basis. 4/28/15; The Alliance is convening regular meetings with the Regional Centers and they have begun documenting meetings with meeting minutes. Meetings are scheduled to occur quarterly. This deficiency is closed.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
2.4.1 MCP must ensure IHA completion is based on valid methodology to measure compliance.	The Alliance has refined its methodology to include relevant codes that qualify as an Initial Health Assessment (IHA), as outlined in the corresponding attachment. The IHA workgroup and the Clinical Quality Improvement Workgroup (CQIW) reviewed and approved the IHA codes on 04/01/2015. The IHA codes will be reviewed and approved by the CQIW on an annual basis.	2.4.1 – IHA Codes	04/01/2015	The MCP used 46 billing service/procedure codes in 2013 to determine IHA compliance. Not all of these codes describe the complexity or time element required for a comprehensive initial health assessment. An IHA consists of a comprehensive history, physical and mental health examination, a behavioral assessment and diagnoses in order to assess, manage a member's acute, chronic and preventative health needs and develop a plan of care. In 2014, billing service/procedure codes were reduced to 27. Codes being used could result in inaccurate data, providing erroneous results and delay continuous quality improvement. When the MCP used 46 codes, compliance was 36%. When revised to 27 codes, compliance fell to 2%. In a review of meeting minutes of the Clinical Quality Improvement workgroup, they did not document specific actions or measures to improve IHA compliance rates. 4/28/15; The Alliance has revised its methodology to include relevant codes that will qualify as an Initial Health Assessment. The codes will be reviewed and approved on an annual basis. 6/26/15; CPT Code 99385 for newly established

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				patients is code for an initial comprehensive preventive medicine evaluation and management of an individual including age, and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, etc. Previously used codes were limited in scope, focused on minor problems and may not have required the presence of a physician. This deficiency is provisionally closed. MCQMD notes expected implementation is 4/1/15. MCQMD will follow up to verify the Alliance is utilizing codes that correlate with the actual performance of an IHA thus allowing the Alliance to track IHA performance.
2.4.2 MCP must ensure opportunities for improvement in IHA compliance are identified and continuous quality improvement processes include actions to facilitate compliance.	The Alliance will continue to explore continuous quality improvement opportunities to ensure compliance with IHA completion standards, including the following initiatives: - The Alliance initiated a new member incentive in September 2014 to help address IHA completion rates among new members. - On 03/25/2015, the Alliance	2.4.2 – IHA workgroup agenda	New member incentive: 09/02/2014 Board approval of provider incentive: 03/25/2015 Evaluation of RDPI: 04/08/2015	4/28/15; The Alliance has initiated new member incentives starting September 2014 to help address IHA completion rates for new members. A new provider incentive program was approved to encourage new member access and connection to their medical home and for providing an initial member appointment. The Alliance sponsored a performance improvement program to assist in reducing wait time, improve overall satisfaction, increase access and promote timely IHA completion rates.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	Board approved a new provider incentive program to encourage new members' access and connection to their medical home and provide an incentive for PCPs for providing an initial member appointment. - The Alliance sponsored a Rapid Dramatic Performance Improvement (RDPI) for interested, qualified clinics, through Coleman Associates. RPDI is an on-site program designed help clinics with work process redesign recommendations to reduce wait times, improve satisfaction and facilitate access. RDPI reinforces processes that increase access and promote timely IHA completion rates. - The Alliance is developing additional access-related interventions, such as performing proactive new member orientations, with a greater emphasis on PCP selection and scheduling of first appointments and utilizing a vendor to remind members to complete their IHA.			The Alliance has conducted additional access-related interventions; including new member orientations, assisting in selection of PCP, and reminders to complete IHAs. This deficiency is closed. 6/26/15; Request the Alliance submit documentation supporting its efforts to combat low IHA compliance rates based upon outreach efforts being taken. 8/4/15; The Alliance has been exploring barriers to 120 day IHA compliance, breaking down potential causes from different perspectives: patients, PCP, the Alliance, resources, communication, miscellaneous. They have compared data – median compliance rates for 2013 (43%) to 2014 (21%); however, median number of IHAs completed has jumped up from 1,280 in 2013 to 1,566 in 2015, largely due to increased enrollment. The Alliance has also conducted a nurse phone pilot program to gain greater understanding of potential barriers contributing to low IHA compliance rates. This continues to be a work in progress for the Alliance, they are working to identify barriers to IHA compliance rates, initiated both member and PCP incentive programs to increase compliance. MCQMD is changing the status of this

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				deficiency to provisionally closed. MCQMD will follow up with the Alliance to verify compliance with the contractual requirements and/or compliance efforts by the Alliance are indicating substantial progress toward achieving compliance.
3. Access and Availability of Care				
3.1.1 MCP must ensure the Clinical Quality Improvement Committee reviews, compares and evaluates the results of access related surveys.	The Alliance formalized a quarterly interdisciplinary review of access-related surveys and data through the CQIW in 2015 to review, compare, evaluate, and develop recommendations from survey results and other member- and access-related trends and patterns. This formalized quarterly review includes reports of access-related data and surveys from relevant operational departments. Further, a CQIW summary will be reported to CQIC on 04/20/2015 for further follow up and action. Please see the corresponding attachments referring to CQIW.	3.1.1 – CQIW Annual Calendar 3.1.1 – Policy #300-8030 – Monitoring Network Compliance with Accessibility Standards	Access results discussed at CQIW: 02/19/2015 Policy #300-8030 revised: 04/08/2015	There was no documented evidence surveys were reviewed, compared or evaluated. 4/28/15; The Alliance submitted revised Policy #300-8030 – CQIW reviews and evaluates information regarding accessibility and availability on a quarterly basis. Information can be obtained through capacity reporting, enrollee and provider surveys, grievance and appeals. The CQIW takes appropriate action to identify the causes of timely access deficiencies and takes steps to bring network into compliance. Actions may include provider education, modifications to provider payment policy or incentive programs. This deficiency is provisionally closed pending DHCS approval of revised Policy #300-8030. 5/13/15; Policy #300-8030 has been reviewed and is hereby approved with respect to the medical audit.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				6/26/15; This deficiency remains provisionally closed. In an effort to verify implementation, MCQMD requests the Alliance to submit the last quarterly report from the CQIW addressing accessibility/availability. 8/4/15; The Alliance submitted CQIW meeting minutes, Timely Access Survey, Provider Satisfaction Access Related Survey, Comparison of Access Metrics and the Alliance's own CAHPS survey. Based upon the meeting minutes, the Alliance is exploring a variety of ways to address access-related issues. This deficiency is closed.
3.1.2 MCP must ensure the Member Services Guide provide accurate information regarding the expected time to receive various appointments that are consistent with contractual requirements and the MCP's accessibility standards.	The Alliance has revised the language in its EOC on page 30, to align with the Contract and the Alliance's Accessibility standards.	1.1.2 - Member Handbook - Evidence of Coverage	Member Handbook revised: 10/14/2014, DHCS approval: 11/07/2014	The Member Services Guide is not consistent with Policy #401-1509 Accessibility Standards. 4/28/15; The Alliance has revised its Member Handbook to reflect accessibility standards and note DHCS approval. 6/29/15; Requested copy of Policy 401-1509 - Accessibility and reviewed access standards in relation to contractual requirements. The Policy aligns with the accessibility standards set forth in the contract; however, the EOC still appears vague and should provide clear information regarding expected wait times to receive various

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				appointments that is consistent with the contract and Policy #401-1509 as recommended in the audit. 8/4/15; The Alliance submitted a revised version of their EOC with the requested changes that now provide clear information pertaining to expected wait time that is consistent with the contract and Alliance policy. This deficiency is closed.
3.1.3 MCP must ensure providers who did not comply with the MCP's accessibility standards submit corrective action plans as required by policy and state regulation.	The Alliance has revised Policy #300-8030 – Monitoring Network Compliance with Accessibility Standards to align with contractual requirements. The Alliance will request corrective action plans from providers that fail the same access standard for 2 consecutive years. The Alliance will obtain a response from each provider notified of a corrective action. In addition, if the quarterly compliance monitoring or annual accessibility survey discloses that the Alliance's network is not sufficiently ensuring timely access, the Alliance will take all necessary and appropriate actions to identify the timely access	3.1.1 – Policy #300-8030 – Monitoring Network Compliance with Accessibility Standards	Policy #300-8030 revised: 04/08/2015 CAPs to issue: 06/01/2015	Providers were sent letters who had access deficiencies; however no corrective action plans were requested as required by policy and regulation. 4/28/15; Note that individual provider groups that fail to meet timely access standards receive written notice identifying which standard(s) were not met. Corrective action plans (CAPS) are then required from each provider group that fail the same access standard for two consecutive years. Quarterly monitoring of any provider group affected by a corrective action to ensure compliance. Should a provider group remain out of compliance, additional follow up and potential peer review is required. This deficiency is provisionally closed. MCQMD Compliance Unit will follow up with

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	deficiency and steps to bring the network into compliance. The Alliance will provide written notice to all contracted providers affected by the corrective action. The Alliance will issue any necessary corrective actions for the 2014 Timely Access Survey results by 06/01/2015.			the Alliance and provide technical assistance as warranted. 5/14/15; The Alliance will request corrective action from providers that fail the same access standard for two consecutive years. If the Alliance has issued any corrective action plans to providers relating to access standards, DHCS requests an example of one such CAP in order to verify implementation. 6/22/15; The Alliance submitted an example of a letter sent to a network provider whose office did not meet the timely access standards for two consecutive years, thus requiring corrective action. The provider was given 60 days to respond indicating how they planned to achieve compliance. The provider's response is due by 7/27/15. MCQMD requests the Alliance submit the provider's CAP response in order to verify implementation and compliance. 8/11/15; The Alliance submitted four examples of provider responses to the timely access standards requirements. Each provided different issues/perspectives on their difficulty meeting the timely access standards.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				8/17/15; This deficiency remains provisionally closed. MCQMD will continue to monitor Alliance progress toward achieving provider compliance with timely access standards.
3.3.1 MCP must develop and implement policies and procedures to effectively monitor and ensure appropriately licensed professionals are available for triaging/screening member telephone and after-hours calls.	The Alliance will implement a Nurse Advice Line to ensure appropriately licensed professionals are available for triaging / screening member calls 24 hours a day. The Nurse Advice Line was approved by the Alliance Board on 10/22/2014. The Alliance is currently in the process of finalizing the contractual and operational requirements with a vendor to provide 24-hour triage and screening services. This Nurse Advice Line will augment the provider after-hours requirement. The Alliance's target implementation date is no later than 08/31/2015.	3.3.1 – October 2014 Board Meeting Minutes	08/31/2015	25% of PCPs surveyed indicated that their practice did not provide telephone appointment triage or screening services, such as answering machines or answering services. The MCP does not contract with a 24-hour Nurse Advice Line, or offer 24-hour, 7 days per week telephone triage/screening to members affected by PCPs who do not provide these services. 4/28/15; The Alliance, during the Managed Medical Care Commission proposed a Nurse Advice Line for triaging and screening member calls 24 hours a day. The Alliance researched three vendors – all offering NCQA certification, direct answering by licensed RNs using evidence-based protocols under physician supervision, Spanish speaking providers and interpreters. The advice line was approved and a vendor has been selected – implementation expected by 8/31/15. This deficiency is provisionally closed. MCQMD Compliance Unit will follow up with the Alliance and provider technical assistance as

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				warranted. 5/14/15; Requested Alliance to submit preliminary documentation of proposed advice line being developed. When the Alliance can demonstrate they are moving forward addressing this deficiency, the provisional closure will be deemed closed. 6/22/15; The Alliance submitted a copy of the amendment to their agreement with McKesson Health Solutions implementing a 24-7 Nurse Advice Line to support the contractual requirements of the Alliance's Medi-Cal contract. The executed agreement calls for the advice line to launch in July 2015. 8/17/15; This deficiency is provisionally closed. MCQMD will follow up with the Alliance to verify that the 24-7 Nurse Advise Line is up and running.
3.7.1 MCP must develop and implement policies and procedures to ensure the monitoring of and access to a 72-hour supply of covered outpatient medications in emergency situations.	Alliance Policy #403-1126 – Pharmaceutical Services Access has been revised to incorporate the procedure to monitor and ensure access to a 72-hour supply of medically necessary medications in emergency circumstances. On a quarterly basis, the Alliance will review access to a 72-hour supply of	3.7.1 – Policy #403-1126 – Pharmaceutical Services Access	04/15/2015	The MCP utilizes a Pharmacy Benefits Manager. The MCP contracts with three 24-hour pharmacies. They rely on ER departments to provide a sufficient supply of medication in emergency situations until members can get their prescriptions filled. The MCP does not have policies and procedures in place to monitor and ensure that emergency

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	covered outpatient medications by sampling members with a given diagnosis. Results will be reported to the Alliance's Pharmacy and Therapeutics (P&T) Committee.			drugs are actually provided to members as required by the contract. The MCP did not completely or consistently determine ER compliance with these requirements throughout the audit period. 4/29/15; The Alliance submitted revised Policy #403-1126 which ensures the timely provision of medically necessary pharmaceutical services through a pharmacy network managed by a PBM. …emergency services…provider shall provide a sufficient quantity (at least a 72-hour supply) of medically necessary drugs… 24 hour access is provided by any 24-hour pharmacy. PBM is authorized to enter a five day override if the pharmacy states that it is for an emergency. The Alliance will receive an emergency override report from the PBM. The Member Handbook informs members of their right to obtain an emergency supply of medications and their right to file a grievance. Member grievances related to obtaining medically necessary medications in emergency situations are monitored. Alliance staff will also monitor compliance by reviewing a sample of specific emergency department visits to ensure access to a 72-hour supply of medications.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				Monitoring will be done quarterly and reported annually to the P&T Committee. This deficiency is provisionally closed. MCQMD Compliance Unit will follow up with the Alliance and provide technical assistance as warranted. 5/14/15; Policy #403-1126 has been reviewed and is hereby approved with respect to the medical audit. 6/30/15; The Alliance has developed a procedure to monitor and ensure access to a 72-hour supply of medication in emergency situations. Random sampling based upon diagnosis codes, member grievances related to obtaining necessary medication in emergency situations. This deficiency was noted as being a repeat finding. This deficiency is provisionally closed. In order to verify implementation of these new monitoring procedures, MCMQD requests the Alliance submit a copy of their monitoring report submitted to the P&T Committee. Further follow up will be conducted to determine whether the Alliance is complying with the requirements.
4. Members' Rights				
4.1.1 MCP must ensure all	The Alliance ensures that all 24-hour		01/29/2015	MCP allows non-clinical Member Services

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
24-hour and 30-day grievances receive routine review by clinical staff to ensure that quality of care grievances are not overlooked.	and 30-day grievances receive routine review by clinical staff to ensure that quality of care grievances are not overlooked. Furthermore, on a monthly basis, QI staff review the monthly Staff Grievance Review Committee (SGRC) report and identify any cases which merit further discussion or which should be tracked for continuous quality improvement. In addition to the monthly SGRC meeting case review, clinical QI staff meets regularly with Grievance staff to review grievances. Training was provided to Grievance staff on 01/29/2015.			Representatives the discretion to decide what qualifies as a 24-hour grievance and what qualifies as a 30-day grievance. The only oversight of this process is conducted by non-clinical grievance coordinators. These same staff members are responsible for differentiating between QOC and QOS grievances. 4/29/15; The Alliance ensures all 24-hour and 30-day grievances are reviewed by clinical staff to ensure quality of care grievances are not overlooked. On a monthly basis, the QI Staff reviews grievance reports to identify cases which merit further discussion or should be tracked for continuous quality improvement. Clinical staff also meets with the Grievance staff on a regular basis to review grievances. Training was also provided to Grievance staff on 1/29/15. 6/30/15; This deficiency is provisionally closed pending verification that clinical staff review 24-hour and 30-day grievances and what qualifies as each, as well as, ensure quality of care grievances are not overlooked. MCQMD will continue to follow up to ensure compliance.
4.1.2 Provide training to member services staff and grievance coordinators on how to identify quality of care grievances.	The Alliance has developed a standard training for Member Services Representatives (MSRs) and Grievance staff that include clear criteria for identifying quality issues.	4.1.2 – QI Training for GCs and MSRs	04/03/2015	See comments above. A&I cited a lack of consistent clinical oversight. 4/30/15; The Alliance developed a training program titled Identifying Quality of Care

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	This training has been reviewed and approved by the Alliance Medical Directors.			Grievances. This training is provided to the Member Service Representatives and Grievance staff. The training includes case categorization (24-hr v. 30 day), QI Grievance Process and identifying quality issues. Training based on 2014 audit findings. Training was approved by the Chief Medical Officer. This deficiency is closed.
4.1.3 MCP to ensure grievances requiring a full investigation are not inappropriately classified as 24-hour complaints by providing training to member services staff and conducting oversight of the grievance intake process.	Alliance MSRs do not determine whether a case is considered a 24-hour or 30-day grievance. The Alliance has developed a standard training for Grievance Coordinators to appropriately classify grievances, which includes clear criteria to categorize grievances as 24-hour or 30-day cases. This training has been reviewed and approved by the Alliance Medical Directors. Furthermore, Grievance Supervisors will conduct ongoing monitoring and oversight of grievance categorization.	4.1.2 – QI Training for GCs and MSRs	04/03/2015	Again, clinical oversight cited. Several of the 146 24-hour grievance reviewed should have had more action taken than just a PCP switch. 4/30/15; The Alliance developed a training program for identifying quality of care grievances, including case categorization, etc. Training program was approved by Chief Medical Officer. Note that Grievance Supervisors will conduct ongoing monitoring and oversight of grievance categorization (24-hr v. 30 day). This deficiency is closed.
4.1.4 Amend practices to ensure quality of care grievances are not closed prematurely before the resolution of the potential	Alliance Grievance staff will not close grievance cases involving quality issues until the case is resolved by an Alliance Medical Director and documented as such in		04/07/2015	Per A&I 24-hour complaints were often resolved with a switch of PCP which was resolved in the member's view. This however, didn't investigate the potential underlying issue which meant grievances were not thoroughly investigated and

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
quality issue and ensure grievance resolution letters are accurate.	the Alliance Care Tracking System. Grievance Coordinators will draft resolution letters that accurately articulate the Medical Directors' determination.			the opportunity for continuous quality improvement was lost. Per A&I – 24-hour grievances are exempt from a written acknowledgement letter and response, but not a complete investigation and resolution of the underlying complaint. There is no consistent clinical oversight. 4/30/15; Per the Alliance, grievances involving quality issues will not be closed until the case is reviewed by a medical director and documented in the tracking system. Grievance letters to be drafted that accurately articulate the medical directors' determination. This deficiency is provisionally closed. MCQMD will follow up to verify that quality of care grievances are being reviewed by the medical director or designee and documented in the tracking system.
4.1.5 Amend practices to ensure quality of care grievance resolution letters are not mailed prior to the review of the grievance by a medical director.	Grievance resolution letters involving quality issues are not sent to members until an Alliance Medical Director has resolved the quality issue.		04/07/2015	4/30/15; The Alliance developed a training program to identify quality of care grievances. Grievance coordinators monitor and provide oversight of grievance categorization. Grievances with quality issues are reviewed by medical directors and resolution letters are sent to members accurately articulating the medical directors' determination.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				8/17/15; This deficiency is provisionally closed. MCQMD will follow up to verify quality of care grievances are being reviewed by medical directors and resolution letters being sent to members are accurate.
4.3.1 MCP to ensure all cases, regardless of media type, involving unauthorized PHI disclosures as of 1/1/14 are reported to DHCS immediately.	The Alliance has revised Policy #105-4029 – Breach Risk Assessment and Response to clarify that the Alliance notifies DHCS immediately by telephone and email, or fax, upon the discovery of a breach or discovery of a suspected security incident involving data that was provided to DHCS by the Social Security Administration (SSA), in alignment with Exhibit G, Provision J.1 of its Med-Cal contract with DHCS. Effective 01/09/2015, all breaches and suspected incidents involving SSA data are reported to DHCS immediately by telephone and follow up e-mail.	4.3.1 – Policy #105-4029 – Breach Risk Assessment and Response	04/08/2015	NOTE: There was an amendment to the contract effective 1/1/14 that now requires…immediate notice to DHCS for discovery of any (electronic media or any other media) breach or unauthorized disclosure of PHI and a notice within 24 hours for suspected security incident or suspected disclosure of PHI. 4/30/15; The Alliance submitted revised Policy #105-4029 Breach Risk Assessment and Response. The policy indicates all suspected security incidents impacting members are reported to DHCS within 24-hours. All potential breaches or suspected security incidents involving data provided to DHCS by the SSA impacting members are reported to DHCS immediately by phone, email or fax. All breaches impacting 500 or more members are reported to DHCS…Annually, a summary of all breaches reported to DHCS are reported to HHS. This deficiency is closed.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
4.3.2 MCP must ensure all cases involving unauthorized PHI disclosures are reported to the DHCS Information Security Officer in addition to the DHCS Privacy Officer within the required timeframe of the amended contract.	Effective 01/09/2015, the DHCS Information Security Officer was included in all reporting of unauthorized PHI disclosure within the required timeframes.		01/09/2015	4/30/15; The Alliance has adopted a procedure to report all breaches of suspected incidents involving SSA data are reported to DHCS immediately by telephone, email or fax. Effective 1/9/15, in addition to reporting unauthorized PHI to the DHCS Privacy Officer, the Alliance will include the DHCS Information Security Officer on reports as well. This deficiency is closed.
4.3.3 MCP needs to update Policy #100-2028 to reflect requirements of amended contract.	Alliance Policy #100-2028: Security Breach was retired on 10/22/2014 and replaced by policy #105-4029 – Breach Risk Assessment and Response, which is consistent with the Alliance's contract with DHCS.	4.3.1 – Policy #105-4029 – Breach Risk Assessment and Response	Policy #100-2028 retired: 10/22/2014 Policy #105-4029 revised: 10/22/2014, DHCS approval: 02/09/2015	Contract Amendment No. 17 requires (1) immediate notice to DHCS for discovery of any electronic media or in any other media breach or unauthorized disclosure of PHI and (2) a notice within 24 hours for suspected security incident or suspected disclosure of PHI. 4/30/15; The Alliance's Policy #105-4029 outlines the contractual requirements relating to notice of unauthorized disclosure of PHI. DHCS approved this policy on 2/9/15. This deficiency is closed.
4.3.4 MCP needs to update Policy #100-2005 to refer to the Compliance	Alliance Policy #100-2005 – HIPAA Privacy and Security Committee was retired on 11/26/2014. The Alliance's	4.3.4 – Alliance Compliance Plan	Policy #100-2005 retired: 11/26/2014	4/30/15; Policy #100-2005 has been retired. The Alliance's revised Compliance Plan/Committee ensures appropriate safeguards…to protect the

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
Committee that recently absorbed the HIPAA Privacy and Security Committee.	Compliance Plan demonstrates that the Compliance Committee oversees the Alliance's HIPAA function.		Compliance Plan revised: 06/02/2014	confidentiality of health information and ensure compliance with HIPAA. The Compliance Manager coordinates operational HIPAA activities and staff will complete HIPAA compliance training. This deficiency is closed.
5. Quality Management				
5.1.1 MCP needs to ensure QPIP identifies and acts on opportunities to improve care and services including continuous quality improvement of access related issues, the grievance process and initial health assessment compliance.	The Alliance will ensure that it identifies and acts on opportunities to improve care and services through continuous quality improvement regarding access issues, IHA compliance, and the grievance process. As noted in finding 3.1.1, in 2015 the Alliance formalized a quarterly interdisciplinary review of relevant data through the CQIW to review, compare, evaluate, and develop recommendations from survey results and other member and access-related trends and patterns. This quarterly review will identify opportunities for improvement and develop actions towards those opportunities.	2.4.2 – IHA workgroup agenda 3.1.1 - CQIW Annual Calendar	02/19/2015	Per the 2013 Provider Satisfaction Survey – Only 38.5% of responding providers felt the MCP had adequate numbers of high quality specialists to whom they could refer. Call center trending reports repeatedly identified access as an issue for both PCPs and specialists. Lack of quality improvement relating to continuous trend of IHA completion non-compliance. In April 2014, IHA compliance rate was approximately 4%. 4/30/15; The Alliance will ensure that it identifies and acts on opportunities to improve care and services through continuous quality improvement. The Alliance has formalized a quarterly interdisciplinary review to compare, evaluate and develop recommendations from survey results and access-related trends and patterns.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				6/30/15; As a result of several access-related issues, the Alliance formalized a quarterly review process to identify, evaluate and development recommendations for quality improvement of access-related issues. This deficiency remains provisionally closed; however, MCQMD requests the Alliance to submit a copy of the May 2015 CQIW report as evidence the Alliance is identifying and acting on opportunities to improve access to care. 8/4/15; The Alliance submitted CQIW meeting minutes, Timely Access Survey, Provider Satisfaction Access Related Survey, Comparison of Access Metrics and the Alliance's own CAHPS survey. Based upon the meeting minutes, the Alliance is exploring a variety of ways to address access-related issues. This deficiency is closed.
5.2.1 The MCP does not routinely review the Medi-Cal Suspended and Ineligible Provider List. MCP must develop a policy and procedure to check the Medi-Cal Suspended and Ineligible	The Alliance updated Policies #300-4030: Credentialing Criteria and Identified Issues and #300-4090: Ongoing Monitoring of Provider Credentials and Issues to reflect monitoring of the Medi-Cal Suspended & Ineligible (S&I) list. These policies were approved by the	5.2.1 – Policy #300-4030 – Credentialing Criteria and Identified Issues 5.2.1 – Policy #300-4090 – Ongoing Monitoring of	12/17/2014	4/30/15; The Alliance submitted revised Policy #300-4030 which establishes criteria for review and approval of provider credentials including providers must not be listed on the Medi-Cal Suspended and Ineligible Provider List. The Alliance submitted revised Policy #300-4090 establishes ongoing monitoring requirements including eligibility for

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
Provider List routinely to verify that providers have not been suspended and are eligible to participate in Medi-Cal per contract requirements.	Peer Review and Credentialing Committee (PRCC) on 12/10/2014. Additionally, the Alliance's practice of reviewing the Medi-Cal S&I list for all new and re-credentialed providers, and on a monthly basis for all providers was reinstated in September 2014.	Provider Credentials and Issues		participation in Medicare/Medicaid and Medi-Cal programs through the OIG, LEIE, and Medi-Cal Suspended and Ineligible List on an ongoing basis to ensure provider status remains free of sanctions or probationary conditions. Providers who are excluded from participation are not eligible for payment… 5/15/15; Policies #300-4030 and #300-4090 have been reviewed and are hereby approved with respect to the medical audit. This deficiency is closed. 6/30/15; The Alliance's credentialing process includes routine monitoring of the National Practitioner Data Bank and the Medical Board of California. This process has been revised to include routine reviews of the LEIE and Medi-Cal Suspended and Ineligible List. This deficiency is closed.
5.4.1 MCP must ensure Compliance Committee approves delegates prior to delegation of quality improvement activities.	The Alliance will ensure that Compliance Committee approval is obtained prior to the delegation of future Quality Improvement activities. Adherence to the existing delegated oversight requirement was reiterated during the April 15, 2015 Compliance Committee meeting.		04/15/2015	Two delegates began providing services in January 2014 and the compliance committee didn't approve them until April 2014. 4/30/15; The Alliance will ensure Compliance Committee approval prior to delegation of future Quality Improvement activities. This was reiterated during the April Compliance Committee meeting.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	The Alliance notes that its use of Beacon-CHIPA in January 2014, prior to Compliance Committee's approval of the entity, was a result of the very short timeframe provided to implement the new mental health benefit for Medi-Cal members. The Alliance began providing services on 01/01/2014 through a letter of agreement with Beacon-CHIPA, in order to meet members' needs for mental health services, as required by DHCS. All departmental subject matter experts reviewed and recommended Beacon for approval through a documented pre-delegation assessment by 01/24/2014. However, Compliance Committee approval of the document was not obtained until 04/15/2014. The Alliance did not execute the contract with Beacon-CHIPA until 06/11/2014, after Compliance Committee approval of delegation.			6/30/15; The Alliance has a delegation oversight process in place. Pre-delegation and annual oversight audits are performed; however, in their effort to implement the new mental health benefit, pre-delegation approval hadn't been obtained prior service being performed. This point was reiterated during the April Compliance Committee meeting. This deficiency is closed.
5.4.2 MCP to update Policy #401-1101 to accurately reflect that QI delegation is overseen by the Compliance Committee.	The Alliance updated Policy #401-1101: Quality and Performance Improvement Program to reflect oversight of QI delegation by the Compliance Committee.	5.4.2 – Policy #401-1101 – Quality and Performance Improvement Program	02/18/2015	NOTE: Just need to update current policy to reflect change in oversight. 4/30/15; The Compliance Committee performs regular verification of delegated entities to ensure appropriate standards are met. The Compliance Committee works with claims data and QI to

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				address potential quality issues. 5/15/15; Policy #401-1101 has been reviewed and is hereby approved with respect to the medical audit. This deficiency is closed.
6. Administrative and Organizational Capacity				
6.1.1 MCP to ensure grievances involving potential quality of care issues involves the Chief Medical Officer or Medical Director prior to resolution.	As noted in the Alliance's response to finding number 4.1.4, Alliance Grievance staff will not close grievance cases involving quality issues until the case is resolved by an Alliance Medical Director and documented as such in ACT. Grievance Coordinators will draft resolution letters that accurately articulate the Medical Directors' determination.		04/07/2015	A&I recommends the Alliance amends its practice so that potential quality of care grievances are not resolved prior to the completion of the PQI investigation and the CMO or Medical Director is involved. 4/30/15; Per the Alliance, grievances involving quality issues will not be closed until the case is reviewed by a medical director and documented in the tracking system. Grievance letters to be drafted that accurately articulate the medical directors' determination. 6/30/15; This deficiency is provisionally closed. MCQMD will follow up to verify that grievances involving potential quality of care issues are being reviewed by the Medical Director prior to being closed.

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
6.4.1 MCP must ensure new provider training begins within ten working days after the active status date and is completed within 30 calendar days as required by the contract.	The Alliance notes that the training requirement identified in this deficiency is an Alliance-DHCS contract requirement specific to Primary Care Providers and not to all providers. The Alliance has always trained all of its new providers. The Alliance has only documented compliance with the DHCS contract provision for PCPs. In response to DHCS' findings, the Alliance revised Policy #300-6030 – New Provider Training to state that training is provided and documented for all newly contracted providers.	6.4.1 – Policy #300-6030 – New Provider Training	Policy revised: 04/08/2015 Training documented for all newly contracted providers: 04/20/2015	7/15 new providers did not receive any new provider training at all within the required time frame. Of the 8 new providers that did receive training, one provider was trained after the ten working days requirement to begin. 4/30/15; The Alliance submitted revised Policy #300-6030 which reflects training of all newly contracted providers will begin no later than 10 working days after being placed on active status and completed within 30 days. 5/15/15; Policy #300-6030 has been reviewed and is hereby approved with respect to the medical audit. This deficiency is closed.
6.5.1 MCP must update Policy #100-3001 to include the new staff composition of the Special Investigations Unit and the integration of the FWAPC into the Compliance Committee.	Alliance Policy #100-3001 – Fraud, Waste and Abuse Prevention Program, describing the Alliance's Fraud Waste and Abuse Prevention (FWAP) Program, was retired and replaced on 07/01/2014. Policies #105-3001 – Program Integrity: Fraud, Waste & Abuse Prevention Program and #105-3002 – Program Integrity: Special Investigations Unit Operations were	6.5.1 – Policy #105-3001 – Program Integrity: Fraud, Waste & Abuse Prevention Program 6.5.1 – Policy #105-3002 – Program Integrity: Special Investigations Unit Operations	Policy #100-3001 retired: 07/02/2014 Policies #105-3001 and #105-3002 revised: 06/11/2014, DHCS approval: 11/18/2014	4/30/15; The Alliance submitted revised Policy #105-3001 which replaced #100-3001. The FWAP Program is operated by Program Integrity and Compliance Program personnel. Program Integrity is a component of the Alliance Compliance Program and activities and outcomes are reported to the Compliance Committee. The Alliance submitted revised Policy #105-3002 which describes the special investigations unit operations. The policy describes the

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	implemented on 07/01/2014. Policy #105-3001 indicates that the FWAP program activities are reported to the Compliance Committee. Policy #105-3002 accurately describes the composition of the Special Investigations Unit.			structure and standards of the SIU. The SIU is principally responsible for facilitating investigations into suspected/actual FWA. Both policies have been approved by DHCS. This deficiency is closed.
6.5.2 MCP must ensure suspected FWA cases are preliminary investigated and reported to DHCS within ten working days of the date the MCP becomes aware of, or is on notice of, such activity as required by the contract.	The Alliance will ensure all cases of suspected fraud and/or abuse are reported to DHCS within 10 working days where there is reason to believe that an incident of fraud and/or abuse has occurred.		04/15/2015	4/30/15; Policy #105-3002 reflects the requirement of reporting to DHCS within 10 business days when the results of a preliminary investigation provides reason to believe fraud and/or abuse exists. Two potential cases were identified and reported to the SIU. There was no evidence The Alliance conducted a preliminary investigation. The cases were delegated out for medical records reviews which were completed months after these cases were originally identified. This deficiency is closed.
6.5.3 MCP must ensure no providers listed on the Medi-Cal Suspended or Ineligible List are employed or contracted by the MCP.	The Alliance updated Policy #300-4030: Credentialing Criteria and Identified Issues to indicate that the Alliance ensures providers are not on the Medi-Cal S&I list prior to contracting with them. The Alliance revised Policy #300-4090: Ongoing	5.2.1 – Policy #300-4030 – Credentialing Criteria and Identified Issues 5.2.1 – Policy #300-	12/17/2014	4/30/15; The Alliance submitted revised Policy #300-4030 which establishes criteria for review and approval of provider credentials including providers must not be listed on the Medi-Cal Suspended and Ineligible Provider List. The Alliance submitted revised Policy #300-

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	Monitoring of Provider Credentials and Issues to reflect ongoing monitoring of providers against the Medi-Cal S&I list. These policies were approved by the Peer Review and Credentialing Committee (PRCC) on 12/10/2014. Additionally, the Alliance's practice of reviewing the Medi-Cal S&I list for all new and re-credentialed providers, and on a monthly basis for all providers was reinstated in September 2014.	4090 – Ongoing Monitoring of Provider Credentials and Issues		4090 establishes ongoing monitoring requirements including eligibility for participation in Medicare/Medicaid and Medi-Cal programs through the OIG, LEIE, and Medi-Cal Suspended and Ineligible List on an ongoing basis to ensure provider status remains free of sanctions or probationary conditions. Providers who are excluded from participation are not eligible for payment… 5/15/15; Policies #300-4030 and #300-4090 have been reviewed and are hereby approved with respect to the medical audit. This deficiency is closed.
6.5.4 MCP must ensure all services ordered or prescribed by a sanctioned or suspended provider per the State and Federal lists are not covered by the Medi-Cal program.	The Alliance will ensure that all services ordered or prescribed by a sanctioned or suspended provider are not covered, in accordance with Title 22, CCR Sec. 51303(k) as described in Policy # 105-3003 – Suspended or Ineligible Providers.	6.5.2 - Policy # 105-3003 – Suspended or Ineligible Providers	04/22/2015	4/30/15; The Alliance submitted Policy #105-3003 which ensures all claims for services ordered, prescribed or rendered by providers deemed ineligible…are not covered. Credentialing notifies Program Integrity of providers deemed ineligible…by verification of the Medi-Cal Suspended and Ineligible List, OIG and LEIE. The policy describes prevention of payments and/or recoupment of overpayments. This deficiency is closed.

Submitted by: Alan McKay **Date: 04/15/2015**
Title: Chief Executive Officer