ATTACHMENT A
Corrective Action Plan Response Form

Plan Name: CCAH

Review/Audit Type: DMHC SPD Medical Survey **Review Period: January 1, 2014 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

Utilization Management

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
Deficiency 1: The MCP must ensure NOA letters include a description of the specific criteria or guidelines used to make a determination in written notifications to members and providers.	The Alliance will ensure that Notice of Action (NOA) letters and provider correspondence include a clear and concise explanation of the reasons for the Alliance's decisions, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. To ensure Utilization Management (UM) Prior Authorization staff understands this requirement, all UM staff was retrained on 07/14/2015 to include the appropriate criteria or guidelines used to make determinations. Medical Directors will not approve NOA letters not meeting the requirement for inclusion of the criteria or guidelines. The UM & Pharmacy Services Coordinator is conducting a final review of NOA letters prior to the letters being mailed out. The UM & Pharmacy Services Coordinator will notify the UM Manager – Prior Authorization of any NOAs without clear criteria regarding why the request was denied. In these	1 – Prior Auth Staff Agenda 07142015 1 – 2014 Audit follow-up NOA Staff Training	Staff trained: 07/14/2015 Monitoring Process Finalized by: 09/30/2015	For decisions to deny, defer, or modify requests for prior authorization, the Alliance does not consistently: Provide written notification to members and/or their authorized representative notifying them of the decision. Inform members of their right to a State Hearing. Include a description of the criteria or guidelines used to make the determination in written notifications to members and providers. This deficiency involves three appeals files. In two of the three appeals files reviewed, the Alliance did not send a NOA letter to the member. During the survey review, the Alliance acknowledged that the two files were mistakenly classified as post-service requests. Due to the misclassification, NOA letters were not sent to members and therefore not informed of their right to a State Hearing. As a result, Utilization Management staff received in-service training to correct this practice.

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	instances, the UM Manager will review the identified case with the originating staff to revise the NOA and ensure staff understands the requirement.			DHCS notes that the Alliance has acknowledged this deficiency and taken corrective action to address this matter. Going forward, the Alliance is to ensure proper classification of prior authorization requests and members receive written notification of prior authorization decisions. The Alliance did not consistently provide members with NOA letters notifying them of the Alliance's decision or of their right to a State Hearing. Furthermore, none of the letters reviewed included a description of the criteria or guidelines the Alliance used to make a determination. 8/19/15; Review indicates that Alliance policy is consistent with contractual requirements. Alliance Policy mirrors Section 1367.01(h)(4) which states in part, Plan must provide members and providers with a description of the criteria and guidelines used to make a decision. This deficiency involves a review of three (3) appeal files. Two (2) files were acknowledged to be misclassified by the Alliance so no NOA letters were sent to the members. The NOA letters on one (1) file did not contain a description of the criteria or guidelines used to make a decision. The Alliance provided retraining (7/14/15) on NOA letter requirements and instituted a new procedure to ensure correspondence provides

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
				clear and concise explanations, descriptions, and criteria/guidelines used to make decisions. Medical Directors will not approve NOA letters not meeting these requirements. Additionally, Pharmacy and UM Coordinators will also conduct reviews of NOA letters prior to being mailed to members. The Alliance has proposed implementing new internal procedures to verify NOA letters are being reviewed for documentation of appropriate criteria and guidelines prior to being approved and mailed to members. This deficiency involved one file and does not appear to be a systemic problem. This deficiency is closed.

Availability and Accessibility of Services

Deficiency 2: The MCP lacks monitoring policies and procedures to ensure its network of primary care physicians are located within 30 minutes or 10 miles of a member's residence.	The Alliance acknowledges this finding, and respectfully requests recognition of Alliance's existing policy on monitoring of the time and distance standards, Policy 300-5050, last submitted to DHCS on 10/27/2014. In addition, the Alliance submitted a request to DHCS for appropriate approval for those rural areas of its Service Area that does not comply with the standards on 05/14/2015. Finally, the Alliance continues to use existing resources to monitor member to provider proximity and is implementing GeoAccess reporting.	2 – Policy 300-5050 – Geographic Accessibility Standards 2- Request for alternative time and distance standards	Policy submitted to DHCS: 10/27/2014 Request submitted: 05/14/2015	Time and distance standard: The Alliance shall maintain a network of Primary Care Physicians that are located within 30 minutes or ten (10) miles of a member's residence unless the MCP has a DHCS approved alternative time and distance standard. The Alliance indicated that it did not have any geo-access reports for the survey period. The Alliance's Member Distribution Dashboard shows the number of members and providers within each zip code; however, there is no measurement of the proportion of members who are within 30 minutes or 10 miles of at least one PCP. 8/18/15; The Alliance previously submitted a request for reconsideration of this deficiency centering on its concern with the language of the finding as written in the subject report when in the Alliance's opinion, the audit team was more directly concerned with the adequacy of the Alliance's monitoring mechanisms. The Alliance submitted Policy #300-5050 Geographic Accessibility Standards which acknowledges contractual time and distance standards. Requires provider network staff to identify providers for recruitment, identify referral patterns and pursue agreements with non-contracted providers, monitor terminations which may affect time and distance standards. The Alliance's Member Distribution Dashboard depicts the number of members and providers

				within a zip code and the number of members linked to a provider within a zip code; however the Alliance admits the Dashboard is limited in its ability to directly measure the proportion of members who are within the current time and distance standards of a PCP. MCQMD recognizes the Alliance's existing policy with regard to contractual time and distance standards. In May, the Alliance requested approval for alternative time and distance standards for the rural areas of its service area. DHCS is currently in the process of developing new processes for addressing alternative access standards. MCPs will have input in the new alternative access standards. In the meantime, the Alliance has acknowledged limitations of its Dashboard to directly measure the proportion of members who are within the 30 minute/10 mile timely access standard of a PCP and in an effort to enhance existing policy, the Alliance has purchased GeoAccess software and is currently developing a report that will measure members within the contractual time and distance standard. This deficiency is provisionally closed. MCQMD will continue to monitor and follow up with the MCP to ensure that the current contractual time and distance standard is being met. 9/28/15; The Alliance was requested to provide a current status of their development of a GeoAccess report to measure members located within the time and distance standards. The Alliance developed a report that will measure member access within the contractual standards. They submitted four reports, one representing the entire network, and three other reports

				represented county-specific data. Contract calls for the Alliance to maintain a network that complies with contractual time and distance standards unless DHCS approves alternative standards. Primary issue appears to involve Monterey County and its rural population. The Alliance has previously requested alternative time and distance standards for rural areas. Alternative time and distance standards are in development. *This deficiency remains provisionally closed. In the absence of DHCS approved alternative standards, MCQMD will continue to monitor the Alliance and their efforts to ensure contractual time and distance standards are achieved. *
Deficiency 3: The MCP must take effective action to improve quality of care where deficiencies in appointment availability are identified.	The Alliance issued notices to providers that failed the same access standard for 2 consecutive years on 05/27/2015. The Alliance requested that each of these providers submit a responsive corrective action plan by 07/27/15. In addition, the Alliance conducts quarterly compliance monitoring of its network to ensure timely access. In the event 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 appropriate and necessary actions to identify the timely access deficiency as well as steps to bring the network into compliance. The Alliance will provide written notice to all	3 – TA CAP Sample Letter	05/27/2015	If the Alliance's network is not sufficient to ensure timely access, the Alliance shall investigate and implement corrective action, including appropriate action to identify the cause of the access deficiencies. 40/338 providers/provider groups failed one of two timely appointment questions. The Alliance selected 20 providers/provider groups for follow up. The Alliance's annual access audit revealed some of its providers and provider groups did not meet the appointment availability requirements. Further, the Alliance had knowledge that some providers had been non-compliant for two consecutive years. The Alliance did not investigate or implement any corrective action to bring these individuals into compliance. 8/19/15; The Alliance submitted an example of a letter sent to a network provider whose office did

	contracted providers affected by the corrective action.			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 was due by 7/27/15. MCQMD appreciates the difficulty individual providers may have maintaining compliance with the timely access standards, especially in rural areas. However, individual providers for which corrective action plans have been requested, the Alliance must ensure evidence of corrective action is being met. Per Alliance policy, the Provider Services Network Manager conducts quarterly monitoring of any provider affected by corrective action to ensure compliance. MCQMD requests the Alliance submit its quarterly monitoring report for review and evaluation. 9/15/15; Received/reviewed four Alliance responses to PCP corrective action relating to timely access. One provider has extended their business hours and is working weekends in order to accommodate enrollees. Some rural PCPs are triaging or providing screening services to enrollees in order to determine if a later appointment will not have a detrimental impact on the enrollee's health, as allowed under Title 28 1300.67.2.2. The Alliance is reminding PCPs that this information needs to be noted in the enrollee's medical record. Also, if triaging indicates an enrollee cannot wait and provider cannot accommodate the enrollee, the Alliance has requested provider communicate back with the PCP so the enrollee can be referred to another provider.

				This deficiency is closed.
Deficiency 4: The MCP must take effective action to improve quality of care where deficiencies in telephone triage or screening services are identified.	The Alliance implemented a Nurse Advice Line on 07/01/2015 to ensure appropriately licensed professionals are available to provide telephone triage services to Alliance members 24 hours a day. This Nurse Advice Line will augment the provider after-hours requirement.		07/01/2015	Contract calls for the Alliance to require providers to maintain a procedure for triaging member's telephone calls and ensuring that a physician or an appropriate licensed professional under a physician's supervision is available for after-hours calls. 90/338 providers/provider groups failed to provide telephone appointment triage or screening services, such as an answering machine or answering service. The Alliance selected 20 providers/provider groups for follow up. The Alliance's annual audit revealed some providers and provider groups did not meet the requirements for telephone procedures and after-hours calls. The Alliance did not send deficiency letters or implement any corrective action to bring these individuals into compliance. 8/19/15; Contract calls for a physician or appropriately licensed professional under a physician's supervision be available for after-hours calls. The Alliance identified deficiencies in its provider network relating to telephone procedures and after-hours calls and has implemented a 24/7 Nurse Advice Line slated to begin in July 2015. This deficiency is provisionally closed. MCQMD will follow up with the Alliance to verify the Nurse Advice Line is up and running.

				9/21/15; Nurse Advice Line is up and running as of July. The Alliance submitted monthly report from vendor which details caller intent/nurse recommendation, calls handled, calls abandoned and outcomes. The nurse advice line will augment provider after-hours requirement for telephone triaging. This deficiency is closed.
Deficiency 5: The MCP does not ensure that print materials distributed to members contain accurate appointment availability information.	The Alliance will revise the identified language in its Medi-Cal Member Handbook to align with the Alliance's contract with DHCS, and the Alliance's accessibility standards regarding appointment availability. These revisions are currently being made. Once all revisions are complete, the Alliance will submit the Medi-Cal Member Handbook to DHCS for review and approval.		08/01/2015	The contract requires the Alliance's written member information to ensure members' understanding of health plan covered services, processes and ensure the member's ability to make informed health decisions. The member handbook and newsletter contained non-urgent primary care and urgent care appointment information that is inconsistent with contractual requirements. Non-urgent care appointments are to be scheduled within 10 business days of request. Urgent care appointments that do not require prior authorization are to be scheduled within 48 hours. Urgent care appointments that require prior authorization are to be scheduled within 96 hours. 8/19/15; As reflected in the A&I Medical Audit CAP, the Alliance submitted a revised version of their EOC with the required changes which now provides clear information pertaining to expected wait time that is consistent with the contract and Alliance policy. This deficiency is closed.

Member Rights

Deficiency 6: The MCP does not ensure that grievances related to medical quality of care issues are consistently referred to the Medical Director.	Alliance Grievance staff no longer closes grievance cases involving quality issues until the case is resolved by an Alliance Medical Director and documented as such in the Alliance Care Tracking system. Grievance Coordinators draft and mail resolution letters that accurately articulates the Medical Directors' determination, and only once the quality of care issue is resolved.		04/07/2015	The contract requires grievances related to medical quality of care issues to be referred to the Medical Director. All standard grievances containing quality of care issues were appropriately elevated; however, none of the exempt grievances containing quality of care issues (9 of 28 files reviewed) were forwarded to the Medical Director for review. 8/20/15; Both contractual language and Alliance policy require grievances with medical quality of care issues be referred to the Medical Director for resolution. By not referring exempt grievances containing quality of care issues to the Medical Director, the opportunity for continuous quality improvement is not being met. The Alliance has proposed that Grievance staff will no longer close grievance cases involving medical quality of care issues until they are resolved by the Medical Director and documented in the Alliance Care Tracking System. This deficiency is provisionally closed. MCQMD will follow up with the Alliance to verify that exempt grievances are being referred to the Medical Director when presenting quality of care issues. 9/21/15; The Alliance submitted copy of monthly report depicting exempt grievances being referred for potential quality issues. Survey found exempt grievances containing potential quality of care issues were not being forwarded to the Medical Director for review.

				This deficiency is closed.
Deficiency 7: The MCP does not consistently state in its written notifications, the criteria, clinical guidelines, or medical policies used to make determinations.	The Alliance will ensure that resolution letters clearly state the specific criteria or guidelines used to make the determination. The language included in the letters will include a clear and concise explanation of the reasons for the Alliance's decisions, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity, as needed. Please see the Alliance's response to Deficiency 1 for additional information regarding correction of this finding.		07/02/2015	Resolution letters are required to clearly state the criteria, clinical guidelines, or medical policies used in reaching a determination. 21 standard grievance and appeals files were reviewed. Of the four appeals files identified, two appeals failed to provide the criteria, clinical guidelines, or medical policies used to reach a decision. 8/20/15; Review indicates that Alliance policy is consistent with contractual requirements. Alliance Policy mirrors Section 1367.01(h)(4) which states in part, Plan must provide members and providers with a description of the criteria and guidelines used to make a decision. This deficiency involves a review of two (2) upheld appeal files that did not clearly state the criteria, clinical guidelines or medical policies used to make a decision. The Alliance provided retraining (7/14/15) on NOA letter requirements and instituted a new procedure to ensure correspondence provides clear and concise explanations, descriptions, and criteria/guidelines used to make decisions. Medical Directors will not approve NOA letters not meeting these requirements. Additionally, Pharmacy and UM Coordinators will also conduct reviews of NOA letters prior to being mailed to members.

				The Alliance has proposed implementing new internal procedures to verify NOA letters are being reviewed for documentation of appropriate criteria and guidelines prior to being approved and mailed to members. This deficiency involved two files and does not appear to be a systemic problem. This deficiency is closed.

Quality Management

Deficiency 8: The MCP does not maintain a system to ensure accountability for delegated quality improvement activities, including continuous monitoring and evaluation of delegated functions.	The Alliance acknowledges this finding, and respectfully requests recognition of Alliance's existing policy on delegated oversight, Policy 105-0004 – Delegate Oversight, approved by DHCS on 05/22/2014, as well as the supplemental documentation provided regarding the Alliance's delegated oversight activities and those specific to the review and approval of the entity at issue.	8 – Policy 105-0004 – Delegate Oversight	Policy approved by DHCS: 05/22/2014	In January 2014, the Alliance contracted with a behavioral health specialty plan which required the delegate to submit a variety of reports on a quarterly and annual basis. However, the Quality Improvement Director hasn't received any reports and the Alliance's lack of timely follow up or implementation of corrective action demonstrates a lack of continuous monitoring, evaluation and oversight of delegated functions. 8/18/15; The Alliance previously submitted a request for reconsideration of this deficiency. In January 2014, the Alliance contracted with a behavioral health specialty plan through a letter of agreement in order to implement the new mental health benefit. The actual contract wasn't executed until June 2014. Several functions were delegated to the specialty plan and the contract requires the delegate to submit a variety of reports on an annual and quarterly basis. Review of Compliance Committee Meeting Minutes (4/16/14) indicates that delegate oversight policy (#105-0004) was approved, replacing existing policy. The delegated entity, Beacon was approved and necessary annual and quarterly reporting required was confirmed. Overall assessment: It is the Alliance's policy to perform ongoing monitoring of delegated activities and ensure each delegated entity's ability to fulfill its responsibilities prior to contracting with the entity. In the Alliance's effort to meet the timeframe for implementation of the new mental health benefit, services began through a letter of agreement with the actual

				contract being finalized in June 2014. It was indicated in the report summary that quarterly reports were not available for review. However, per the Compliance Committee Meeting minutes, necessary quarterly reports were received in July 2014 and were reviewed by subject matter experts, who complete periodic review forms and recommend to the Compliance Committee if they should be approved. The Alliance also submitted a Delegate Oversight Activity Report which provides background on the delegate oversight program and compliance staff recommendations with respect to quarterly report submissions. It appears that the Alliance is conducting continuous monitoring, evaluation and oversight of delegated functions. This deficiency is hereby closed.

Submitted by: Alan McKay **Date: July 16, 2015**
Title: Chief Executive Officer