



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



EDMUND G. BROWN JR.  
GOVERNOR

Anna Tran, CEO  
Care 1st Partner Plan, LLC  
601 Potrero Grande Drive  
Monterey Park, CA 91755

RE: CAP Close out Letter for 1115 Waiver SPD Enrollment Survey - 2014

Dear Ms. Tran;

The Department of Managed Health Care (DMHC) conducted an onsite 1115 Medicaid Waiver Seniors and Persons with Disabilities (SPD) Enrollment Survey of Care 1st Health Plan, a Managed Care Plan (MCP), from December 3, 2013 through December 6, 2013. The audit covered the review period of October 1, 2012, through September 30, 2013.

On September 18, 2014, the MCP provided DHCS with a response to its Corrective Action Plan (CAP) originally issued on July 10, 2014.

A review of all remaining open items has been found to be in compliance and the CAP is hereby closed. The enclosed report will serve to provide as DHCS's final response to the MCP's CAP.

Please be advised that in accordance with Health & Safety Code Section 1380(h) and the Public Records Act, the final report will become a public document and will be made available on the DHCS website and to the public upon request.

If you have any questions, contact Mr. Edgar Monroy, Chief of Plan Monitoring Unit at (916) 449-5233 or [edgar.monroy@dhcs.ca.gov](mailto:edgar.monroy@dhcs.ca.gov).

Sincerely,

*Original Signed by Nathan Nau*

Nathan Nau, Chief  
Medical Monitoring and Program Integrity Section

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cc: Tereza Majkovic, Contract Manager  
Department of Health Care Services  
Medi-Cal Managed Care Division  
P.O. Box 997413, MS 4400  
Sacramento, CA 95899-7413

**CORRECTIVE ACTION PLAN**

**Plan Name: Care 1st**

**Review/Audit Type: DMHC Enrollment  
30, 2013**

**Review Period: October 1, 2012 to September**

<b>Deficiency Number and Recommendation</b>	<b>Action Taken</b>	<b>Evidential Documentation Implementation</b>	<b>Completion/ Expected Completion Date</b>	<b>DHCS Comments</b>
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<p><b>Utilization Management:</b></p> <p>1. The Plan's Utilization Management program does not ensure appropriate processes are consistently used to review and approve the provision of medically necessary services.</p>	<p>UM Department has revised the UM policy # 70.2.50 - Prior Authorization Review and Approval Process to ensure that appropriate processes are used to review and approve medically necessary services. The policy also specified in page 2 of 10 that "Care1st shall authorize medically necessary services..... even though; the procedures or services may not be listed as covered by Medi-cal. The "Treatment Authorization Request (TAR) and Non-Benefit List" published by the Department of Health Care Services shall be used as a guideline only."</p> <p>UM Department has also created a new policy 70.2.83 – Definition and Application of Medical Necessity Provision for Treatment Authorization Requests This policy has spelled out in pages 4 of 5 and 5 of 5 about the special review process – all overturned appeals that are based on inappropriate interpretation of</p>	<p>See attached UM policy # 70.2.50</p> <p>See attached UM policy # 70.2.83 See attached Medical Services Committee Agenda (#10,C), Policy &amp; Procedure Summary Sheet, and Committee member sign-in sheets</p> <p>See attached meeting agenda, In-Service for Prior Authorization Review Process</p> <p>Date: July 30, 2014</p> <p>Sign- in sheet</p>		<p><b>8/8/14</b> The MCP submitted a revised P&amp;P, #70.2.50 – Prior Authorization Review and Approval Process, and a new P&amp;P #70.2.83 – Definition and Application of Medical Necessity Provision for Treatment Authorization Requests. The MCP also submitted a copy of the Medical Services Committee meeting agenda, July 30, 2014, and a copy of the meeting sign-in sheet. The new and revised P&amp;P's were reviewed and approved at this meeting. Also submitted were a copy of the agenda from the UM clinical staff meeting, July 14, 2014, and a copy of the sign-in sheet. The MCP states that the subject of the deficiency finding was reviewed at the meeting, as well as the new and revised P&amp;P's. The implementation of the processes included in</p>

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	<p>guidelines or benefits, the CMO will be responsible to meet with the Medical Director or physician reviewer who made the incorrect decisions to discuss the error and provide guidance in rectifying a recurrence of the review deficiency in order to prevent similar occurrences in the future.</p> <p>The Quality Improvement Committee reviews and trends Appeals information (including those from the special review process) and initiates improvement activities, including corrective action plans.</p> <p>Both Policy 70.2.50 and Policy 70.2.83 were presented and approved by the Medical Services Committee on July 30, 2014</p> <p>UM clinical staff meeting was conducted on July 30, 2014 and the attendees included the Corporate Medical Director (via phone), San Diego Medical</p>			<p>the P&amp;P's should ensure that occurrences of the delay of medically necessary care are eliminated, or held to the bare minimum.</p> <p><b>This item is closed.</b></p> <p><b>Note: It is recommended that future surveys revisit this issue to ensure the operationalization of the P&amp;P's is achieving the desired results.</b></p>

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	<p>Director, VP of Medical Services and Prior Authorization Case Mangers.</p> <p>The VP of Medical services reviewed the UM finding in the SPD Enrollment Medical Survey Report.</p> <p>The Corporate Medical Director and the VP of Medical Services reviewed the overturned appeal case cited in the Medical Survey Report.</p> <p>The VP of Medical Services discussed the new review process for non-benefit services to include medical necessity criteria before submitting the case to the Medical Director for review.</p> <p>The Corporate Medical Director discussed the special review process for overturned appeal cases by the CMO.</p>			

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<p><b>Availability and Accessibility:</b></p> <p>2.A The Plan does not adequately ensure that Physical Accessibility Reviews are conducted on all provider sites that serve a high volume of SPD's.</p>	<p><b>1. Change in Staffing: Additional Staffing was added to the QI Department area handling Facility Site Review.</b></p> <p>A. Changes were made in the both the licensed and non-licensed staffing that are handling, processing and performing Physical Assessment Review Surveys(PARS) for the High Volume specialists. Additional New Registered Nurse Reviewers and a Non-Licensed Reviewer were hired increasing FTE's from 2 to 5 reviewers and 1 Certified Nurse Reviewer is now assigned to only San Diego County. <b>(See attachment #1 QI-FSR Org. Chart)</b></p> <p><i>To close this finding the MCP must submit a copy of the referenced report.</i></p> <p>Care1st Response 9-3-14: Deficiency 2A The new quarterly</p>	<p>See Attachment # 1 QI-FSR Org Chart Attach 2A High Vol Specialist Report</p> <p>See Attachment #2 DMHC HiVol Spec List-PARS-072814</p>	<p>San Diego Nurse Assigned 3<sup>rd</sup> Quarter of 2013. 2 Additional Nurse Reviewers Hired 3<sup>rd</sup> Quarter of 2013 Non-Licensed FSR Auditor hired 2<sup>nd</sup> Quarter 2014</p> <p>June 14, 2014</p> <p>October 8, 2014</p>	<p><b>8/8/14</b> The MCP submitted an organization chart to evidence that staffing levels have been increased to improve the number of Physical Accessibility reviews for provider sites that serve a high volume of SPD beneficiaries. The MCP also submitted a copy of a report showing that with the increased staffing, and, in conjunction with the site review data provided by other Plans within the Health Plan Collaborative, site reviews have been completed on all 65 provider sites identified as high SPD volume specialty providers. The MCP also states a new quarterly Management Reports is being created to identify high SPD volume specialists to ensure site reviews are scheduled within 60 days of their identification.</p>

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	<p>report has been developed. Please see attach 3<sup>rd</sup> Quarter High Volume Specialist Report.</p> <p>B. In addition in January 2014 a Medical Director was hired exclusively for Quality Improvement and has fostered and implemented new automation related to tracking the Physical Accessibility Data and provides Medical Director support within the department for issues related to Panel closures and improving relationships with providers to foster the provider education components of physician and ancillary offices to increase network compliance with the requirements for site review.</p> <p><b><u>2. Changes in Process.</u></b></p> <p>A. The addition of the new staff and reallocation of 1 Review Nurse to San Diego County Only provided us the ability</p>			<p>To close this finding the MCP must submit a copy of the referenced report. This item remains open.</p> <p><b>Update 9/9/14 –</b> The MCP submitted “The new quarterly report, 3rd Quarter High Volume Specialist Report.”  <b>This item is closed.</b></p>

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	<p>to have 33 of the 65 identified High Volume specialists Physical Accessibility Review Surveys completed by 12/31/2013. With this effort and access to the Health Plan Collaborative data which indicates the other plans in the Collaborative and the reviews they were assigned, we are able to show on this attachment 65 of the 65 were completed by 6/14/14. <b>(see attachment #2 DMHC HiVol Spec List-PARS-072814)</b></p> <p><b>3. <u>Tracking and Monitoring</u></b>            Since the requirement is for high volume specialists we will be creating a Management Report for tracking high volume specialists. This is being created for Care 1st Provider Network and Facility Site Review Databases. These reports when ready will be run quarterly to ensure that we are tracking new</p>			

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	high volume specialists and getting PARS scheduled within 60 days of their identification.			
2.B The Plan does not ensure that Physical Accessibility Review information is consistently available to members through the Plan’s website and provider directories.	<p><b>1. <u>Changes in Process</u></b>            Staffing will be assigned as we implement the new automated system that will include working with Collaborative Health Plans to obtain data to upload into Care1st’s new system and use of production and management reports for tracking high volume specialists and automated processes to transfer this data and assure posting of Physical Accessibility data on the website and in the Plan directory so the data is consistently available to the Members. <b>(See attachment #3 Mock Directory Entry.</b></p>	See Attachment #3 Mock Directory Illustration	October 8, 2014	<p><b>8/8/14</b> The MCP submitted a copy of a mock provider directory to demonstrate the Physical Accessibility information to be published for provider sites. To close this finding the MCP must submit a copy of a screen-shot from their online directory and a sample from a published printed directory showing the Physical Accessibility information for provider sites. This item remains open.</p> <p><b>Update 9/9/14</b> – The MCP submitted a “screen-shot of the online directory and an example of the plan printed directory showing the Physical Accessibility information for provider sites.”</p>

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				<b>This item is closed.</b>
<p>3.A The Plan's policies to ensure timely access to care do not provide an updated description of the Plan's monitoring procedures,</p>	<p>Add description of Monitoring Process  Status: Completed  The policy has been updated to describe the process. Policy has been approved by committee.  See attached policy  <i>To close this finding the MCP must submit a sample of the referenced third party vendor generated report and actions taken on issues identified in the report</i>  Care1st Response 9-3-14  Deficiency Number 3A and 3B</p> <ol style="list-style-type: none"> <li>1. Please see Attachments A1 and A2 which are the PCP and the Specialist reports from our vendor The Meyers Group.</li> <li>2. Please see Attachment B which is a sample of the CAP letter that was sent to the PCP's and Specialists that failed.</li> <li>3. Please see Attachment C which is a sample of the Medical Services</li> </ol>	<p>70.1.1.8 Access to Care Standards</p> <p>Page 2. – See Tag 1 and Tag 3</p> <p>See Attach A1  See Attach A2</p> <p>See Attach B</p> <p>See Attach C</p>	<p>July 31, 2014</p>	<p><b>8/8/14</b> The MCP submitted a copy of a revised P&amp;P, #70.1.1.8 Access to Care Standards, which includes information that timely access will be monitored by an annual report created by a third party vendor. However, the DMHC survey noted that the MCP was not consistently following its previous policies to monitor timely access, nor requiring CAPs from providers identified as not in compliance with the standards.  To close this finding the MCP must submit a sample of the referenced third party vendor generated report and actions taken on issues identified in the report.  This item remains open.</p> <p><b>Update 9/9/14</b> – The MCP submitted Attachments A1</p>

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	<p>Committee Agenda showing that this process is discussed and overseen by this Committee.</p>			<p>and A2 which are the PCP and the Specialist reports from their vendor The Meyers Group and Attachment B which is a sample of the CAP letter that they sent to the PCP's and Specialists that failed and Attachment C which is a sample of their Medical Services Committee Agenda showing that this process is discussed and overseen by that Committee. <b>This item is closed.</b></p>
<p>3.B Plan's policy does not clearly define its methodology for calculating an annual rate of compliance for appointment wait time standards.</p>	<p>Describe process for calculating annual performance Status: Completed The policy has been updated to describe the process. Policy has been approved by committee. Care1st Response 9-3-14 Deficiency Number 3A and 3B 1. Please see Attachments A1 and A2 which are the PCP and the Specialist reports from our vendor The</p>	<p>70.1.1.8 Access to Care Standards  Page 2. – See Tag 2  See Attach A1 See Attach A2 See Attach B</p>	<p>July 31, 2014</p>	<p><b>8/8/14</b> The MCP submitted a copy of a revised P&amp;P, #70.1.1.8 Access to Care Standards, which defines the methodology to be used by a third party vendor to calculate the rate of compliance for the appointment wait time standards. However, the DMHC survey noted that the MCP was not</p>

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	<p>Meyers Group.</p> <p>2. Please see Attachment B which is a sample of the CAP letter that was sent to the PCP's and Specialists that failed.</p> <p>Please see Attachment C which is a sample of the Medical Services Committee Agenda showing that this process is discussed and overseen by this Committee.</p>	<p>See Attach C</p>		<p>consistently following its previous policies to monitor timely access, nor requiring CAPs from providers identified as not in compliance with the standards.</p> <p>To close this finding the MCP must submit a sample of the referenced third party vendor generated report and actions taken on issues identified in the report. This item remains open.</p> <p><b>Update 9/9/14</b> – The MCP submitted Attachments A1 and A2 which are the PCP and the Specialist reports from their vendor The Meyers Group and Attachment B which is a sample of the CAP letter that they sent to the PCP's and Specialists that failed and Attachment C which is a sample of their Medical Services Committee</p>

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				Agenda showing that this process is discussed and overseen by that Committee. <b>This item is closed.</b>

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<p><b>Member Rights:</b></p> <p>4. For appeals that uphold an original delay, modification, or denial of services based on a determination in whole or in part that the service is not medically necessary, the Plan does not consistently include, along with its written response, the required application for independent medical review (IMR) and instructions, including an envelope addressed to the Department of Managed Health Care.</p>	<p>Staff education &amp; training regarding the member rights to include the IMR, instructions and a copy of envelope addressed to the Department of Manage Health Care in the file.</p> <p>Care1st Response: The minutes from the Member Appeals meeting of September 10, 2014 are attached.</p> <p><b>Care1st Response 9-18-14: Minutes from Member Appeals meetings are enclosed as examples of discussions that take place of appeal cases.</b></p>	<p>P/P change</p> <ul style="list-style-type: none"> <li>-Staff meeting minutes</li> <li>-copy of one file and Department of Manage Health Care envelope</li> <li>-Patient weekly review of this by lead.</li> </ul>	<p>10/2014</p>	<p><b>8/8/14</b> The MCP submitted a copy of a revised P&amp;P, #10.18.2 – Expedited Appeals Process, which contains the requirement, on page 5, that a IMR application, instructions, and an envelope addressed to DMHC is to be included with the MCP’s written response to members whose appeal has been decided as upholding the MCP’s decision to deny coverage for services. Referenced submissions outstanding:</p> <ul style="list-style-type: none"> <li>• Staff meeting minutes</li> <li>• Copy of a file containing the DMHC envelope</li> <li>• Evidence of weekly review</li> </ul> <p>This item remains open.</p> <p><b>Update 9/9/14</b> – The MCP submitted DMHC Envelop</p>

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				<p>file including member rights/appeal and explanation of how they monitor the appeal. In order to close this item the MCP must provide Staff meeting minutes that include the discussion of appeal cases.  <a href="#">This item remains open.</a></p> <p><b>Update 9/18/14 –</b> The MCP submitted Minutes of Appeals meeting.  <b>This item is closed.</b></p>
<p>5. The Plan does not immediately inform members of the right to contact the Department when filing grievances requiring expedited review.</p>	<p>Staff meeting for education &amp; training regarding informing member the right to contact the Department when filing Grievances requiring expedited reviews.</p> <p><b>Care1st Response 9-18-14 Minutes from Member Grievance meetings are enclosed as examples of discussions that take place of appeal cases.</b></p>	<p>-P/P change                      -Staff meeting monitoring by lead of expedited requests</p>	<p>10/2014</p>	<p><b>8/8/14</b> The MCP submitted a copy of a revised P&amp;P, #10.18.2 – Expedited Appeals Process, which contains the requirement, on page 3, that members will be informed, within 24 hours, of their right to contact DMHC in regards to expedited grievances. Referenced submissions outstanding:</p>

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				<ul style="list-style-type: none"> <li>• Staff meeting minutes</li> <li>• Evidence of monitoring of expedited requests.</li> </ul> <p>This item remains open.</p> <p><b>Update 9/9/14</b> – The MCP submitted an explanation of how the member appeal is being handled. In order to close this item the MCP must provide Staff meeting minutes that include the discussion of appeal cases. This item remains open.</p> <p><b>Update 9/18/14</b> – The MCP submitted a minutes of Grievance meeting. <b>This item is closed.</b></p>

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<p><b>Quality Management:</b></p> <p>6. The Plan's Governing Body does not direct ongoing operational Quality Improvement System modifications or track findings for follow-up in response to reports reviewed.</p>	<ol style="list-style-type: none"> <li>1. The Care1st Corporate Compliance Officer and the Director of Corporate Compliance held a training session with the Administrative Assistant (Board Minutes Taker) on July 22, 2014 to ensure that QM minutes are thoroughly documented and must include all discussions, directions, follow-up, recommendations, and actions to be taken by the Board members with respect to quality improvement initiatives/projects.</li> <li>2. The CMO presented to the Board the findings of the DMHC SPD audit on the July 24<sup>th</sup> Board meeting. He did provide an overall review of all the deficiencies but concentrated the discussion in the need for the Board to meet the requirements as identified</li> </ol>	<p>See attachment #1</p>		<p><b>8/8/14</b> The MCP submitted a copy of the sign-in sheet for the referenced training with the Administrative Assistance (Board Minutes Taker). To close this finding the MCP must submit evidence of ongoing modifications to the Quality Improvement System, and a sample of the tracking of findings for follow-up on issues reported. This item remains open.</p> <p><b>Update 9/9/14</b> – The MCP submitted July 24<sup>th</sup> Board minutes which reflect review of Quality Improvement. In order to close this item the MCP must submit evidence of ongoing modifications to the Quality Improvement System, and a sample of the tracking of findings for follow-up on issues reported.</p>

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	<p>on deficiency #6.</p> <p>3. The CMO will review all Board meeting minutes to ensure that they are sufficiently detailed to document the Board's response and involvement to quality of care issues that have been identified through the QI department reporting.</p> <p><b>Care1st Response 9-18-14: The Board minutes from August 26, 2014 are included as attachments reflecting the Quality Improvement discussion. Additionally, the Care1st 2014 Quality Improvement Program is enclosed to reflect Board oversight. The program is included as an attachment and text is highlighted in yellow for your reference in both documents.</b></p>			<p>This item remains open.</p> <p><b>Update 9/18/14 – the MCP submitted updated P&amp;P regarding Quality Improvement Program. This item is closed.</b></p>
7. Quality Management	<b><u>Change in Staffing:</u></b> <b>Additional staffing added to the</b>	See attachment #1	2 Temp nurses hired 1 <sup>st</sup> quarter	<b>8/8/14</b> The MCP submitted an organization chart to

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<p>The Plan Does not adhere to its policy and procedure for timely resolution of potential quality issues and as a result, does not take effective action to improve care when deficiencies are identified to ensure that a level of care, which meets professionally recognized standards of practice, is being delivered to all enrollees.</p>	<p><b>QI Department.</b>  1. <u>Changes</u> were made in the staffing in QI that were handling and processing the Potential Quality of Care Issues. In 2013 additional Clinical Nurse Specialists were being hired. The nursing staffing changed from <u>3 FTE's to 5 and 2 temps were hired</u> to assist with the back log of cases. In 2014 we added 2 more nurses for a total of 7 Fulltime Clinical Nurse Specialists. <b>( See Attachment #1 PQI org. chart)</b>  2. In addition in 2012 and 2013 the Physician Review of Potential Quality Issues were divided among several Medical Directors which impacted the amount of time it took to close cases. In Dec of 2013 a Medical Director was hired exclusively for the QI department and this has also shortened our closure time.</p> <p><b><u>Change in Policy and Process:</u></b>  2.Changes were implemented in</p>	<p>2 PQI Org Chart</p> <p>See Attachment #2 Policy 70.1.1.7 and 70.1.1.7a</p> <p>(See Attachment #3 Tracking and Monitoring Report for Closure Time)</p>	<p>of 2013. 7<sup>th</sup> FTE Clinical Nurse Specialist hired 4-28-14</p> <p>Process changes occurred in the 2<sup>nd</sup> quarter of 2013 and policy revisions were approved 01/1 and 06/14.</p> <p>Report is run quarterly, 6 months and yearly.</p>	<p>evidence the increase in staffing assigned to work on Potential Quality of Care Issues. The MCP submitted a revised P&amp;P, #70.1.1.7 – Clinical Grievance Process, and PQI Process Timeline Summary - #70.1.1.7a. The MCP also submitted a copy of Tracking and Monitoring Report for Closure Time, for grievance cases received between 6/1/13 – 6/1/14, for the San Diego area Medi-Cal line of business. The report shows all 54 cases closed within 180 days, with the average to close at 125 days.  <b>This item is closed.</b></p>

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	<p>the processing of Clinical Grievances in several areas:                      The New Process requires the Clinical Nurse Specialist to request a response from the provider to member allegations and to attach supporting documentation all in the initial request letter. This letter allows the provider 7 business days to respond. (Hospitals are allowed 10 days) If there is no response in 7 days a second letter is mailed requesting a response allowing an additional 5 business days for response and this response is signed by the QI Director. If there is no response to the 2<sup>nd</sup> letter a 3<sup>rd</sup> letter is mailed and is signed by the Medical Director or Chief Medical Officer explaining that the case may now be leveled without input. This letter must go out within 5 days of the provider surpassing the days allowed with letter #2.</p> <p><b><u>Tracking and Monitoring:</u></b>                      3. Tracking and Monitoring of</p>			

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	<p>cases and their aging date was added to our Electronic Monitoring System (Vivaldi) and reports are generated monthly on cases due to be closed and case aging reports are sent to the Director and the Medical Director. Because of the changes we have instituted and because of the monitoring that is available to us we have made a huge improvement in the length of time it is taking us to close cases. Our <b>report (Attachment #3 Tracking and Monitoring Report for Closure Time)</b> indicates that from June 1, 2013 to July 1, 2014 we were <u>100 %</u> compliant on closing cases within 180 days.</p>			