

**ATTACHMENT A
Corrective Action Plan Response Form**



Plan Name: CenCal Health

Review/Audit Type: DMHC SPD Medical Survey

Review Period: January 1, 2014 through July 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
Utilization Management				
Deficiency #1: For decisions to deny, delay, or modify health care service	Medical: 1. Current process for denial notices analyzed	UM Bulletin #1-NOAs	June 19, 2015	The Department reviewed nine standard appeal files to assess the Plan's initial denial process when evaluating requests for medically necessary services. Nine

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<p>requests by providers based in whole or in part on medical necessity, the Plan does not consistently include in its written response:</p> <ul style="list-style-type: none"> • A clear and concise explanation of the reasons for the decision; • A description of the criteria or guidelines used; and • The clinical reasons for the decision. 	<ol style="list-style-type: none"> 2. Updated current processes to include "double check/review" of denial notice content before issuance. 3. Staff educated on new process. 4. Re-evaluate process changes in 120 days from implementation. Address deficiencies as appropriate. <p>Pharmacy (letters generated by MedImpact, Plan's PBM):</p> <p>Pharmacy reviewed the portfolio of scripted responses from the PBM, and on February 24th, 2015, added additional narrative via the review and workflow routing tool to provide more specificity of the denial</p>		<p>July 1, 2015</p> <p>June 24, 2015</p> <p>October 31, 2015</p> <p>February 24, 2015</p>	<p>out of nine (100%) initial denial letters reviewed did not include a clear and concise explanation of the reasons for the Plan's decision. Three out of nine (33%) initial denial letters did not include a description of the criteria or guidelines used to make the decision. Nine out of nine (100%) initial denial letters did not include the clinical reason for the denial.</p> <p>The Plan submitted its updated NOA letter review process to include a double check review of denial notices to ensure content is acceptable before mailing. The Plan also submitted its Pharmacy NOA letter review process which describes its retrospective review of the denial language used. This item is closed.</p>

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	reasons.			
<p>Deficiency #2: For pharmaceuticals that require prior authorizations, the Plan does not consistently:</p> <ul style="list-style-type: none"> • Make a decision within 24 hours or one (1) business day; and • Notify the requesting provider of the decision. 	<p>Pharmacy has updated their "Prospective MRF Denial" process to now include at least twice daily, morning and afternoon review of the queue to ensure compliance with the 24 hour or one (1) business day standard.</p> <p>Plan pharmacy staff is required to adhere to internal process whereby the queue for PA's is processed at the plan within 24 hours. This enables the PBM to notify providers within the 24 hour/1 day time standard, as their support for this function is 24 hour/7 day per week.</p>		February 24, 2015	<p>MedImpact is the Plan's pharmacy benefit management vendor, delegated to review, approve, and deny requests for pharmacy-related services. The Department reviewed nine standard appeal files to assess the initial denial process by the Plan when evaluating requests for medically necessary services. In three of the nine (33%) files reviewed, MedImpact did not make its decision within 24 hours or one business day as required under DHCS-CenCal Contract, Attachment 5, Provision 3(F). In those same three files, MedImpact also failed to notify the requesting provider of the denial.</p> <p>The Plan instituted a twice daily review to ensure that to ensure compliance with the 24 hour (1) business day pharmacy requirement. The Plan submitted its UM Program Description which specifies the 24 hour timeframe for pharmaceutical</p>

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				authorizations. This item is closed
Availability and Accessibility of Services				
<p>Deficiency #3: The Plan does not consistently display level of access results and accessibility symbols in the correct format.</p>	<p>As allowed by SPD requirements, not all Plan providers have been audited using Attachment C of the Facility Site Review tool, and thus the Plan has continued to use the crutch and wheelchair icons for those providers who have self-attested to the Plan their level of accessibility, which has resulted in the appearance of the "inconsistent use" of the various methods for revealing physical accessibility.</p> <p>As of 8/12/15, The Plan's Provider Directory for members no longer displays the crutch or wheelchair icons. The Directory displays DHCS-approved accessibility</p>			<p>The Department reviewed the Plan's April 2014 provider directory and discovered that the Plan did not comply with the access level and accessibility symbol requirements set forth in the DHCS MMCD Policy Letter 12-006. Policy Letter 12-006 requires the Plan to display the level of access results met per provider site as either "Basic Access" or "Limited Access." Instead of listing "Basic Access" and "Limited Access" in the provider directory, the Plan sometimes used an icon of a wheelchair or an icon of a crutch to denote the two types of access, respectively.</p> <p>In addition, Policy Letter 12-006 also requires the Plan to identify whether each provider site has access to parking, building exterior, building interior, exam room, restroom, and certain types of medical equipment. These accessibility</p>

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	<p>indicators only.</p> <p>This latest Directory now utilizes the terms Basic Access and Limited Access, and the other accessibility symbols as defined by Policy Letter 12-006, only for those providers who are designated SPD providers. Also, the "Information for Seniors and Persons with Disabilities" section of the provider directory has been revised to refer to "Limited Access" and utilize the correct definitions, per Policy Letter 12-006.</p>			<p>symbols have been standardized and approved by the DHCS. The Department found that the Plan did not consistently display all of the symbols throughout the provider directory.</p> <p>As of 8-12-15 the Plan uses DHCS approved accessibility indicators and the "Limited" and "Basic" terms. This item is closed.</p>

Submitted by:
Title:

Date: