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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

September 25, 2018

Danita Carlson, Government Relations Director
Central California Alliance for Health
1600 Green Hills Road
Scotts Valley, CA 95066

RE: Department of Health Care Services Medical Audit

Dear Ms. Carlson:

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

On September 21, 2018, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on May 18, 2018.

All items have been reviewed and DHCS accepts the MCP's submitted CAP. The CAP is hereby closed. Full implementation of the CAP will be monitored on the subsequent audit. The enclosed report will serve as DHCS' final response to the MCP's CAP.

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

If you have any questions, feel free to contact me at (916) 345-7831 or Anthony Martinez at (916) 345-7828.

Sincerely,

Hannah Robins, Chief
Compliance Unit

Enclosures: Attachment A CAP Response Form

cc: Jeff Kilty, Contract Manager
Department of Health Care Services
Medi-Cal Managed Care Division
P.O. Box 997413, MS 4408
Sacramento, CA 95899-7413

ATTACHMENT A
Corrective Action Plan Response Form

Plan: Central California Alliance for Health

Audit Type: Medical Audit and State Supported Services **Review Period: 11/01/16 – 10/31/17**

MCPs are required to provide a CAP and respond to all documented deficiencies within 30 calendar days, unless an alternative timeframe is indicated in the letter. MCPs are required to submit the CAP via email in word format which will reduce turnaround time for DHCS to complete its review.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. For deficiencies that require long term corrective action or a period of time longer than 30 days to remedy or operationalize, the MCP must demonstrate it has taken remedial action and is making progress toward achieving an acceptable level of compliance. The MCP will be required to include the date when full compliance is expected to be achieved.

DHCS will maintain close communication with the MCP throughout the CAP process and provide technical assistance to ensure the MCP provides sufficient documentation to correct deficiencies. Depending on the volume and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates, as applicable.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
1. Utilization Management				
1.2.1 The Plan sent member Notice of Action (NOA) letters that contained complex language, did not specifically identify the reasons for its decisions,	The Alliance has updated workflows used by Prior Authorization nurses to process prior authorization requests and draft NOAs to ensure that required elements are included in NOAs and that language level is assessed. The	1.2.1 NOA Workflows 1.2.1 Pharmacy NOA Check List June 2018	2/6/2018	**06/26/18** – The following documentation supports the MCP's efforts to correct this deficiency: - Revised Workflow Process, "NOA Template" (02/06/18) which ensures that the Prior Authorization Nurse reviews NOA template for

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contained misstatements, and were lengthy.	description below outlines the process used by Prior Authorization Nurses to draft NOAs, and subsequent quality review conducted by the Prior Authorization Supervisor and Pharmacy Services Coordinator. When the Plan's Utilization Management Department makes an adverse benefit determination, the Prior Authorization Nurse first selects the correct NOA letter template in the Alliance's prior authorization software. The Prior Authorization Nurse reviews the pre-populated NOA template to ensure that it has been populated with the appropriate information for that specific case (i.e. member name and identifying characteristics, requesting provider, and requested service). The nurse customizes the NOA using the criteria outlined in the NOA workflow			appropriate contractual standards. The Nurse will also check for readability of the NOA using the Flesch Kinkaid readability toll embedded in Microsoft Word. - Revised Workflow Process, "NOA Supervisor Review Workflow" (02/06/18) which ensures that the NOA supervisor or designee will complete a secondary review for clarity, content, appropriateness, and ensures that it meets contractual requirements. - Revised Workflow Process, "Pharmacy NOA Check List" (02/06/18) as evidence that the Pharmacy Services Coordinator completes an additional review of draft NOA letters, which includes checking for grammatical errors, verifying the correct pharmacist is selected at the bottom of the letter. Once reviewed, will send to Medical Director for final approval.

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	and prompts in the NOA template. Key features of this customization include identifying the specific service requested, and ensuring compliance with readability requirements. The nurse outlines the criteria that was used to review for medical necessity, and specific information related to the Medical Director's decision. After drafting custom NOA content, Prior Authorization Nurses check the readability of the NOA using the Flesch Kinkaid readability tool embedded in Microsoft Word. Authorization nurses insert the drafted language into the NOA template. The Prior Authorization Supervisor, or designee, subsequently reviews all NOAs for clarity, content, appropriateness, and ensures that it meets the criteria outlined in the NOA workflow. The Prior Authorization Supervisor			**08/01/18** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: - PowerPoint training, "SBARS, NOAs, & Provider Notices" (07/2018) training materials addresses NOA letter requirements such as clear and concise reason, description of criteria/guideline used, clinical reason, name and telephone number of physician reviewer. - Meeting Agenda's, "Utilization Management Department/Prior Authorization Review Group Meeting" (02/18, 04/18, 06/18, and 07/18) which provides evidence of discussion regarding NOA requirements. - An email (08/01/18) which states that NOA requirements are discussed regularly at Prior Authorization staff meetings, which are used to educate staff on an ongoing basis. Prior Authorization meetings address ongoing issues with NOAs and

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	forwards this NOA to the Pharmacy Services Coordinator for additional review following a similar workflow. See “1.2.1 Pharmacy NOA Check List June 2018” for the tool used by the Pharmacy Services Coordinator. The NOA is then forwarded to the Medical Director for final review, revision and/or approval before the NOA is sent to the member. This revised process was reviewed and approved by Plan Medical Directors on February 6, 2018. Further, the Utilization Management Department has implemented a quality improvement process, where clinical staff periodically review and, as needed, revise this process to ensure compliance with requirements. Process Improvement group outcomes are reported to the Utilization Management Work Group quarterly.			provide training on specific recurring issues. - Audit Tool, “Prior Authorization Audit Tool” (05/4/18 – 07/27/18) which includes weekly audits performed on all Prior Authorization staff that include a comprehensive review of authorizations, including NOA content. **This finding is closed.**

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1.2.2 The Plan's deferred prior authorization policy contained errors and inconsistencies in describing the extension and deferral process.	Effective February 6, 2018, the Alliance updated Prior Authorization workflows to outline the reasons that nurses can defer beyond the 14 days, as follows: (1) member or provider requests delay; (2) at the request of the Medical Director in order to complete Independent Medical Review or other extenuating circumstances (i.e. peer-to-peer review prior to decision); or (3) due to a delay in DME consulting group completing assessment. To ensure compliance, Prior Authorization Supervisors and Prior Authorization Nurse IIs conduct weekly audits of prior authorizations to ensure that the updated processes for writing and sending NOAs to members is being followed. The Utilization Management Prior Authorization Supervisor and/or Manager provide education where non-	1.2.2 404-1201 - Authorization Request Process 1.2.2 Deferral Workflow	2/6/2018	**06/26/18** – The following documentation supports the MCP's efforts to correct this deficiency: - Revised Workflow Process, "Deferral Workflow" (02/16/18) which ensures deferrals can only be made if the MCP can justify how the extension is in the member's best interest. - Revised P&P, 404-1201: "Authorization Request Process" (05/30/18) which has been amended to include a statement that reads, "The decision may be deferred an additional 14 days only at the request of the member or the member's provider, or the MCP can provide justification for the need for additional information. A decision to defer a request must also be in the member's best interest." 09/11/18 – The following additional documentation submitted supports the MCP's efforts to correct this deficiency:

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	compliance with the criteria in the NOA workflow is detected. The Alliance revised policy 404-1201 – Authorization Request Process, accordingly, and revisions were approved on May 30, 2018.			- Desktop Procedure, "Prior Authorization Auditing guidelines" (undated) indicating that the MCP will search for timeliness: • Deferred/Extended: Extended by day 5 or deferred by day 14 (Medi-Cal) - Meeting Agenda, "Utilization Management Department/Prior Authorization Review Group Meeting" (04/10/18) which provides evidence of discussion regarding NOA requirements. - An email (08/01/18) which states that NOA requirements are discussed regularly at Prior Authorization staff meetings, which are used to educate staff on an ongoing basis. Prior Authorization meetings address ongoing issues with NOAs and provide training on specific recurring issues. **This finding is closed.**

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1.2.3 The Plan's policy and practices did not describe withdrawn and void processes for adverse determinations; the Plan applied the void and withdrawal process to cases involving medical necessity.	Upon further review of the verification study referenced in the findings, the Plan determined that the authorization was a duplicative service request. Therefore, the Plan appropriately followed its policies in requesting the provider withdraw the duplicative request. As stated in the Final Report, when the provider was non-responsive to the request to withdraw, the Plan issued a denial. In response to the Final Report, the Plan updated Policy 404-1201 – Authorization Request Process to clarify its void process. Specifically, policy revisions indicate that Alliance staff may void a request for reasons including, but not limited to: member ineligibility,	1.2.3 404-1201 - Authorization Request Process 1.2.3 Void Workflow	6/18/2018	**09/19/18** – The following documentation supports the MCP's efforts to correct this deficiency: - Revised P&P, 404-1201: "Authorization Request Process" (09/21/18) which has been amended to reflect that the Alliance staff may void an authorization request, within the first five business days for routine requests, for reasons including: Member is not eligible with the Alliance, duplicate authorization request, no authorization is required, insufficient or incomplete information is provided to process the authorization request following the Alliance's outreach to the provider to obtain missing, correct or valid information, or after unsuccessful attempts to contact the provider for the required missing or incomplete information.

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	duplicate authorization requests, when no authorization is required, and when the provider requests to withdraw the authorization. The void process is described in the Plan's workflow provided.			- Revised Workflow Process, "Void Workflow" (09/21/18) which has been revised to state, "Void authorization request following Alliance's outreach to, and agreement from, the Provider to obtain missing, correct or valid information, or after unsuccessful attempts to reach the provider." - **09/24/18** Technical Assistance given to MCP explaining that the true issue may be the need for the plan to educate it's doctors to only make OON requests when they are fully substantiated and they can provide supporting documentation for medical necessity. If not, they should be reminding Doctors that in-network referrals do not need to come to the plan (to cut down on the number of these coming in that need to be voided). **This finding is closed.**
1.3.1 The Plan's appeal resolution letters contained complicated and unclear language and did not explain the	The Alliance has resolved this deficiency of not ensuring appeal resolution letters clearly state reasons for its decisions by implementing the newly issued DHCS APL 17-006	1.3.1 AGM180525003 Overturned Resolution Letter 1.3.1 Overturn	7/1/2017	**07/16/18** – The following documentation supports the MCP's efforts to correct this finding: - Sample report, "Grievance Quarterly Activity Report" (June

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reasons for overturned appeals.	Notice of Appeal Resolution (NAR) letter templates into our Appeals and Grievance software system. The new templates ensure all required appeal decision elements are documented and included in the resolution letter to the member. Included in this response are the DHCS-issued templates the Plan has built into the system, including "1.3.1 Overturn" and "1.3.1 Uphold". To ensure resolution letters include a clear and concise description, the Alliance has built required fields into our Grievance and Appeals system module that include the following resolution letter elements: 1. Service requested 2. Whether the letter pertains to a denial, delay, modification, termination, or overturned decision; 3. A clear and concise explanation of the	1.3.1 Uphold		2018) as evidence that the MCP began work to implement process updates required to remedy the DHCS audit findings (page 4). - Two sample case audit examples, "Grievance Audit Review Worksheet" (June 2018) as evidence that the MCP is conducting ongoing monitoring. The Notes section of the Grievance Audit Review Worksheet indicate that the MCP's reviewer checks and ensures that all appeal decisions elements are included in the response letter. - Written response by the MCP (06/26/18) as evidence that the MCP is ensuring that resolution letters are clear and concise: The Alliance has built required fields into our Grievance and Appeals system module that include the following resolution letter elements: 1. Service requested 2. Whether the letter pertains to a denial, delay, modification, termination, or overturned

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	reasons for the decision; 4. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 5. The clinical reasons for the decision regarding medical necessity Resolution letter elements are populated by the Medical Director reviewing the case and finalized by the Grievance Coordinator. The system ensures each required field is populated before generating a letter template. Included in this response is a sample resolution letter demonstrating the implementation of this template. See "1.3.1 AGM180525003_Overturned Resolution Letter_Redacted". Additionally, and as noted in our preliminary response, of the			decision; 3. A clear and concise explanation of the reasons for the decision; 4. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 5. The clinical reasons for the decision regarding medical necessity Resolution letter elements are populated by the Medical Director reviewing the case and finalized by the Grievance Coordinator. **This finding is closed.**

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	21 appeal cases reviewed during the audit period, 3 cases (Cases 16, 17, & 18) were received after the implementation of the NAR template into our Grievance and Appeals system module on 7/1/2017. Two of those cases (Cases 16 & 17) include the specific reason for the appeals decision on the NAR; Case 18 omitted this information in error.			
1.3.2 The Plan did not send acknowledgment letters to providers who had written permission from members to appeal adverse authorization decisions for them.	The Alliance has updated the Grievance process to ensure providers appealing on behalf of members receive an acknowledgment letter. This is documented in workflows used by Grievance Coordinators to process appeal cases. See "1.3.2 Processing an Appeal Work Instruction".	1.3.2 Processing an Appeal Work Instruction	1/1/2018	**04/23/18** – The following documentation supports the MCP's efforts to correct this finding: Desktop procedure, "Processing an Appeal" (04/23/18) as evidence that MCP staff are sending acknowledgment to providers who had written permission from members to appeal adverse authorization decisions for them. The work instruction states, "for cases filed by providers on behalf of members: ensure the acknowledgment letter is addressed and sent to the filing provider. The member may also be CC'd on the

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				letter, but the acknowledgement letter must go to the provider where written consent from the member states the provider may file on their behalf." (page 4) **This finding is closed.**
1.3.3 The Plan did not notify members in writing that it downgraded urgent appeals to routine status and of their right to contest the action.	The Alliance has updated the Grievance process to notify members in writing when requests for expedited resolution are downgraded. The Alliance now includes an explanation to the member in each acknowledgment letter that specifically states their request has been downgraded to standard 30-day case processing timeframes, and outlines their right to contest the action. See "1.3.3 Expedited Appeals Work Instruction".	1.3.3 Expedited Appeals Work Instruction	6/1/2018	**04/23/18** – The following documentation supports the MCP's efforts to correct this finding: Desktop procedure, "Expedited Appeals" (04/23/18) as evidence that the MCP will notify members in writing when requests for expedited resolution are downgraded. The work instruction states, "If a Grievance or Appeal does not meet expedited criteria information must be included in a written acknowledgement letter to the member. The letter should explain that the member's request for expedited status does not meet criteria and the case will be resolved according to standard 30-day timeframes. A member rights document should also accompany this letter so the member is informed of their right to contest the Alliance

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				decision not to expedite the case." (page 1) **This finding is closed.**
4. Members' Rights				
4.1.1 The Plan did not reach a final conclusion about member grievances, date medical director grievance reviews, or document medical director grievance reviews in grievance case files.	The Alliance notes its continued disagreement with this deficiency. The Alliance ensures that all quality and access-related Grievances are assessed by clinical staff to determine whether there is a quality of care component in the complaint. Where quality of care concerns are identified by clinical staff, the outcomes and review of such complaints are separately documented in the Alliance's Potential Quality Issue (PQI) process. However, in effort to respond to this finding the Alliance will make additional process modifications to ensure case		9/1/2018	**06/27/18** – The following documentation supports the MCP's efforts to correct this finding: -Updated P&P, "401-1301: Potential Quality Issue Review Process" (05/09/18) wish was amended to add upon closure of a PQI the Medical Director or CMO assigns the severity level and will make the final determination for clinical grievances. **07/12/18** – The following additional documentation submitted supports the MCP's efforts to correct this finding: -A report titled "Central California Alliance for Health – Administrative Quality Indicators Cumulative Report

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	documentation supports a clear delineation between grievance resolution via the Grievance process and any additional quality investigation via the PQI process. These process modifications are planned for completion by 9/1/2018, and include the following updates: 1. Integrating clinical staff (including RNs and MDs) into the Grievance process within the Grievance and Appeals system module so that all grievance case documentation – including clinical review, assessment and resolution actions – will be documented in a single system; 2. Resolving all clinical issues expressed by the member within the Grievance process within the Grievance and Appeals system module; and			– Q1 2018" as evidence that shows MCP has established a new oversight system in its Administrative Quality Program (AQP) to ensure Medical Director reviews all clinical quality of care grievances. This measure is reported on a quarterly basis, and the reporting in the first two quarters of 2018 have revealed 100% compliance. - A quarterly IRR report titled "MD IRR 2018 Grievance" (January of 2018 through May of 2018) of 13 received grievances performed by the Medical Director as part of MCP's oversight system. -Samples of two quality of care complaints as evidence that shows Medical Director has reviewed these cases. -a flow chart "Redesign Compliant Process" which was revised to reflect MCP's new process of routing QOC issues as of 12/06/2017. New process includes Medical Director

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	3. Limiting referrals from the Grievance process to the PQI process to clinical issues identified as separate and apart from/underlying the members' submitted complaint.			review of every clinical quality of care. 07/16/18 – A written response indicating: "A log of all clinical and non-clinical quality of care Grievances are submitted to the Staff Grievance Review Committee where Medical Directors have access to reviewing and providing oversight of all cases. Additionally, the Medical Director performs a quarterly IRR (10% sample) of member grievances deemed by QI Nurses to not relate to medical or clinical quality of care issues to provide further oversight. Should the IRR reveal a discrepancy, the grievance will be opened as a PQI and retrospectively reviewed by the Medical Director." **08/14/18** – The following additional documentation submitted supports the MCP's efforts to correct this finding: -P&P "105-1002 Member Grievance System" as evidence that shows MCP has a process to send all QOC

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				issues to the Medical Director immediately. These cases are supposed to be reviewed and resolved by the Medial Director within 30 calendar days. (Page 13) -QOC Grievance Log for May and June of 2018 as evidence that shows several QOC grievance issues were reviewed by MCP's Medical Director and were resolved within 30 calendar days. **This finding is closed.**
4.1.2 The Plan did not refer all clinical grievances to a medical director for resolution.	Effective 12/6/2017, Alliance processes have been revised to ensure that all PQIs are routed to a Medical Director for resolution, including cases where no quality of care concerns were identified. The Alliance PQI process systems were re-configured to add a time stamp and the name of the Medical Director who is assigning the severity level for case closure.	4.1.2 401-1301 Potential Quality Issue	12/6/2017	**06/27/18** – The following documentation supports the MCP's efforts to correct this finding: -Updated P&P, "401-1301: Potential Quality Issue Review Process" (05/09/18) was amended to add that upon closure of a PQI the Medical Director or CMO assigns the severity level and would make the final determination for clinical grievances. (Page 3)

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	In addition, Alliance policy 401-1301 – Potential Quality Issue Review Process was revised to indicate that a Medical Director must assign a severity level upon closure.			**07/12/18** – The following additional documentation submitted supports the MCP's efforts to correct this finding: -A report titled "Central California Alliance for Health – Administrative Quality Indicators Cumulative Report – Q1 2018" as evidence that shows MCP has established a new oversight system in its Administrative Quality Program (AQP) to ensure Medical Director reviews of all clinical quality of care grievances. This measure is reported on a quarterly basis, and the reporting in the first two quarters of 2018 have revealed 100% compliance. - A quarterly IRR report titled "MD IRR 2018 Grievance" (January of 2018 through May of 2018) of 13 received grievances performed by the Medical Director as part of MCP's oversight system. -Samples of two quality of care complaints as evidence that shows

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				Medical Director has reviewed these cases. -a flow chart “Redesign Compliant Process” which was revised to reflect MCP’s new process of routing QOC issues as of 12/06/2017. New process includes Medical Director review of every clinical quality of care. **07/16/18** – A written response indicating: “A log of all clinical and non-clinical quality of care Grievances are submitted to the Staff Grievance Review Committee where Medical Directors have access to reviewing and providing oversight of all cases. Additionally, the Medical Director performs a quarterly IRR (10% sample) of member grievances deemed by QI Nurses to not relate to medical or clinical quality of care issues to provide further oversight. Should the IRR reveal a discrepancy, the grievance will be opened as a PQI and retrospectively reviewed by the Medical Director.”

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				08/14/18 – The following additional documentation submitted supports the MCP's efforts to correct this finding: -P&P "105-1002 Member Grievance System" as evidence that shows MCP has a process to send all QOC issues to the Medical Director immediately. These cases are supposed to be reviewed and resolved by the Medial Director within 30 calendar days. (Page 13) -QOC Grievance Log for May and June of 2018 as evidence that shows several QOC grievance issues were reviewed by MCP's Medical Director and were resolved within 30 calendar days. **This finding is closed.**
4.1.3 The Plan's grievance resolution letters sent to members contained incomplete and inaccurate	The Alliance will ensure resolution letters accurately reflect the investigation steps and decisions made about clinical quality of care Grievance cases.		9/1/2018	**08/21/18** – The following documentation supports the MCP's efforts to correct this finding: -Samples of grievance resolution letters sent to the members recently.

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explanations of decisions in clinical quality of care grievances.	As outlined above, the Alliance is working to implement process modifications by 9/1/2018 that will integrate clinical staff into the Grievance process within the Grievance and Appeals system module so that all grievance case documentation – including clinical review, assessment and resolution actions – will be documented in a single system. This will improve the clarity and accuracy of Grievance resolution letters responsive to clinical complaints.			The letters contain a clear explanation of decisions. **This finding is closed.**

Submitted by: Stephanie Sonnenshine **Date: 6/26/18**
Title: Chief Executive Officer