Pages 1 through 75 redacted for the following reasons:
- -
(b)(4)
(b)(4)

Finding ID: 27814

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
27814	#4.56	Timeliness	CAR	CAP Released	2/14/2018	8/20/2018

Contract Number (s)
H1304 , H1969 , H6237 , H5009 , H4605 , H5010 , H1997 , H3817

Condition Language
Sponsor did not effectuate its determinations within 72 hours of receipt of expedited reconsideration requests.

Cause
Sponsor did not have an adequate process in place to ensure that expedited determinations were effectuated in its vendor's system on weekends, holidays and after working hours. Additionally, new Sponsor staff waited for assistance to load one authorization.

Effect
Of the 56 cases evaluated, five cases were non-compliant for late effectuation of approved expedited pre-service reconsiderations. Late effectuation delays enrollees' access to needed medical services.

CAP Submission 1

Project Completion Date: 11/15/2017

Org CAP Submission 1 - 2/8/2018 8:43 PM	CMS CAP Response 1 - 2/14/2018 6:25 PM
During the audit, it was discovered that effectuation requests sent to an east coast vendor, eviCore, on Friday afternoons, Pacific Time, were not effectuating the case until Monday morning, East Coast Time. As of 11/15/17, the vendor has added supervisory coverage until 7:30 PM EST, 4:30PM PST, with their staff working on expedited items during evening, weekend and holiday hours. Cambia created an email template which provided more ease in identifying expedited effectuation cases, the subject line also includes the due date/time. The vendor had also re-educated their staff and provided Cambia team member contact information to eviCore's Appeals and Grievance supervisors and manager as well as their Client Experience Manager. This would allow any effectuation to be escalated to the plan to avoid missed timelines. Additionally, Cambia is receiving a timeliness report capturing effectuation times also allowing our team to be on high alert so we may get involved for escalation purposes.	CAP has been reviewed and deemed appropriate.

Pages 78 through 85 redacted for the following reasons:
- -
(b)(4)

Finding ID: 27801

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
27801	#4.01	Timeliness	CAR	CAP Released	2/15/2018	8/20/2018

Contract Number (s)
H1304 , H1997 , H4605 , H5009 , H1969 , H3817 , H6237 , H5010

Condition Language
Sponsor did not notify enrollees, and providers if the providers requested the services, of its decisions within 72 hours of receipt of expedited organization determination requests.

Cause
Three root causes contributed to this condition. First, Sponsor did not account for the delay caused when a notification was not generated by the cutoff time for same-day mailing. Second, Sponsor staff did not follow established processes for providing notification to enrollees. Third, Sponsor's oversight of its vendor's print shop was insufficient and allowed for mailing delays.

Effect
Of the 251 cases evaluated, 22 cases were non-compliant for late notification of coverage decisions for expedited pre-service requests. Late notification causes delays in enrollees' access to needed medical services.

CAP Submission 1

Project Completion Date: 3/22/2018

Org CAP Submission 1 - 2/8/2018 8:43 PM	CMS CAP Response 1 - 2/14/2018 6:40 PM
Root Cause 1 and 2, 6 members. Cambia's Clinical Services Department is updating our internal process with our mail vendor to ensure that letters needing to be mailed same day can be accommodated to maintain timeliness. The projected date of completion is 03/01/2018. As of 1/2/18, Our vendor's, AIM, print shop has updated their process to ensure sufficient time is allocated for mailings and the vendor also instituted a new process of orally notifying members of decisions by using 3 good-faith attempts. The sponsor's business unit will be auditing timeliness compliance on a weekly basis. Root Cause 3, 16 members. The Pharmacy Services Medical Drug Review Team has implemented new processes, system tracking, and oversight to ensure compliance moving forward. A new external print vendor was implemented on 1/2/18 to deliver same day print and mail fulfillment capabilities 7 days per week and 365 per year. The vendor provides services including same day printing and mailing. The Pharmacy Services Medical Drug Review Policy and Procedure, has been updated to reflect this change. All internal departmental work instructions have been updated to reflect this change also. The vendor returns a daily log of the time and date each letter is delivered into the mail stream. The Review Team has implemented oral notification for all expedited organizational determinations as of 1/22/18. Our internal software application was upgraded on 1/2/18, to capture the time and date of such oral notification. We've hired additional full-time resources to ensure capacity for oral notifications on 100% of all expedited organizational determinations. A new internal work instruction was developed with all employees being trained as of 1/19/18. An oversight audit of 100% of all expedited organizational determinations for Medical Drug Reviews was put in effect on 1/22/18 for a period of at least 60 days. This oversight process captures all elements of the CMS timeliness review to ensure compliance. Upon the 60-day review period, a decision will be made to either extend the 100% oversight review or move the timeliness review elements into the departmental oversight monthly audit samples.	Cap is reasonable, however, Cambia needs to report to AM via email no later than 3/1/2018 on the work being done between Cambia's Clinical Services Department and mail vendor to achieve timely mailing.

CAP Submission 2

Project Completion Date: 3/22/2018

Org CAP Submission 2 - 2/15/2018 2:01 PM	CMS CAP Response 2 - 2/15/2018 2:02 PM
Root Cause 1 and 2, 6 members. Cambia's Clinical Services Department is updating our internal process with our mail vendor to ensure that letters needing to be mailed same day can be accommodated to maintain timeliness. The projected date of completion is 03/01/2018. As of 1/2/18, Our vendor's, AIM, print shop has updated their process to ensure sufficient time is allocated for mailings and the vendor also instituted a new process of orally notifying members of decisions by using 3 good-faith attempts. The sponsor's business unit will be auditing timeliness compliance on a weekly basis. Root Cause 3, 16 members. The Pharmacy Services Medical Drug Review Team has implemented new processes, system tracking, and oversight to ensure compliance moving forward. A new external print vendor was implemented on 1/2/18 to deliver same day print and mail fulfillment capabilities 7 days per week and 365 per year. The vendor provides services including same day printing and mailing. The Pharmacy Services Medical Drug Review Policy and Procedure, has been updated to reflect this change. All internal departmental work instructions have been updated to reflect this change also. The vendor returns a daily log of the time and date each letter is delivered into the mail stream. The Review Team has implemented oral notification for all expedited organizational determinations as of 1/22/18. Our internal software application was upgraded on 1/2/18, to capture the time and date of such oral notification. We've hired additional full-time resources to ensure capacity for oral notifications on 100% of all expedited organizational determinations. A new internal work instruction was developed with all employees being trained as of 1/19/18. An oversight audit of 100% of all expedited organizational determinations for Medical Drug Reviews was put in effect on 1/22/18 for a period of at least 60 days. This oversight process captures all elements of the CMS timeliness review to ensure compliance. Upon the 60-day review period, a decision will be made to either extend the 100% oversight review or move the timeliness review elements into the departmental oversight monthly audit samples.	Cap is reasonable, however, Cambia needs to report to AM via email no later than 3/1/2018 on the work being done between Cambia's Clinical Services Department and mail vendor to achieve timely mailing.

Pages 89 through 101 redacted for the following reasons:
- -
(b)(4)

See Conditions 4.53, 4.09, 4.01.

Corrective Action Plan (CAP) Detail Report

CAP Report Search Parameters: **Program Area** = All **Finding Type** = All **CAP Phase** = All **Finding ID** = All **Element** = All

Audit ID	Parent Organization	Exit Conference Date	Entire CAP Accept Date	Entire CAP Release Date
4025	The Carle Foundation	7/20/2017	12/6/2017	7/25/2018

Program Area: Compliance Program Effectiveness (CPE)

Finding ID: 25523

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
25523	#1.37	Detection Controls and Activities	CAR	CAP Released	12/4/2017	7/25/2018

Contract Number (s)
H1737 , H2591 , S4219 , H1463 , H3471

Condition Language
Sponsor did not review Office of Inspector General (OIG) and General Services Administration (GSA) exclusion lists for any new employee, temporary employee, volunteer, consultant, or governing body member prior to hiring or contracting and monthly thereafter.

Cause
Sponsor's manual process for identifying updates of appointed members to be screened failed to include governing body members that were not employed by Sponsor.

Effect
A total of five governing body members were not screened subsequent to appointment.

CAP Submission 1

Project Completion Date: 12/4/2017

Org CAP Submission 1 - 12/4/2017 11:19 AM	CMS CAP Response 1 - 12/4/2017 12:49 PM
Remediation: The screening process was completed on the five identified governing body members with no identified issues. System/Operational Enhancements: The internal process has been enhanced to ensure all governing body members are included on the exclusion screening list. On a quarterly basis Compliance ensures all governing body members are accounted for and screened.	CAP is accepted. Sponsor has enhanced their process for capturing all governing body members to be included in the monthly screening process.

CAP Monitoring 1

Project Completion Date: 12/4/2017

Org CAP Submission 1 - 7/25/2018 12:03 PM	CMS CAP Response 1 - 7/25/2018 12:05 PM
No response required.	No response required.

Finding ID: 25525

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
25525	#1.03	Prevention Controls and Activities	CAR	CAP Released	12/4/2017	7/25/2018

Contract Number (s)
H2591 , H3471 , H1463 , H1737 , S4219

Condition Language
Sponsor did not distribute its standards of conduct (SOC) and policies & procedures (P&Ps) to employees who support the Medicare business, within 90 days of hire, when there were updates to the P&Ps and annually thereafter.

Cause
Sponsor did not have a process in place to distribute Sponsor’s SOC and compliance P&Ps to all of its First-Tier Downstream and Related Entities (FDRs) during the audit period.

Effect
A total of 39 FDRs did not receive Sponsor's SOC and compliance P&Ps.

CAP Submission 1

Project Completion Date: 12/4/2017

Org CAP Submission 1 - 12/4/2017 11:19 AM	CMS CAP Response 1 - 12/4/2017 12:49 PM
Remediation: All 39 FDRs have received Health Alliance's standards of conduct (SOC) and Compliance Plan Summary and Delegated Vendor Requirements (reference to related P&Ps). System/Operational Enhancement: Health Alliance has created a delegated vendor oversight guide which includes the SOC and Compliance Plan Summary and Delegated Vendor Requirements (reference to related P&Ps). The guide has been distributed to all current FDRs and will be distributed to new FDRs during the onboarding process.	CAP is accepted pending the distribution process of the Vendor Oversight Guide will occur when there are updates to the P&Ps and annually thereafter

CAP Submission 2

Project Completion Date: 12/4/2017

Org CAP Submission 2 - 12/4/2017 1:39 PM	CMS CAP Response 2 - 12/4/2017 3:21 PM
Remediation: All 39 FDRs have received Health Alliance's standards of conduct (SOC) and Compliance Plan Summary and Delegated Vendor Requirements (reference to related P&Ps). System/Operational Enhancement: Health Alliance has created a delegated vendor oversight guide which includes the SOC and Compliance Plan Summary and Delegated Vendor Requirements (reference to related P&Ps). The guide has been distributed to all current FDRs. New FDRs will receive the guide during the onboarding process. All FDRs will receive the guide annually and upon updates.	CAP is accepted. Sponsor's CAP enhances the distribution process of of the SOC and the Compliance P&Ps to all FDRs upon contracting, when there are updates, and annually thereafter.

CAP Monitoring 1

Project Completion Date: 12/4/2017

Org CAP Submission 1 - 7/25/2018 12:03 PM	CMS CAP Response 1 - 7/25/2018 12:05 PM
No response required.	No response required.

Finding ID: 25546

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
25546		Detection Controls and Activities	Observation	CAP Released	11/29/2017	7/25/2018

Observation Language
Sponsor had a dedicated hotline for anonymous and confidential reporting. However, the after business hours recording did not specifically state that the caller could remain anonymous and the call would be treated as confidential (Hotline Test Call).

CAP Submission 1

Project Completion Date:

Org CAP Submission 1 - 11/29/2017 3:58 PM	CMS CAP Response 1 - 11/29/2017 3:59 PM
No CAP Required	No CAP Required

CAP Monitoring 1

Project Completion Date:

Org CAP Submission 1 - 11/29/2017 3:59 PM	CMS CAP Response 1 - 11/29/2017 4:00 PM
No response required	No response required

CAP Monitoring 2

Project Completion Date:

Org CAP Submission 2 - 7/25/2018 12:03 PM	CMS CAP Response 2 - 7/25/2018 12:05 PM
No response required.	No response required

Program Area: Part D Formulary and Benefit Administration (FA)

Finding ID: 25471

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
25471	#2.06	Formulary Administration	ICAR	CAP Released	9/8/2017	7/25/2018

Contract Number (s)
H2591 , H1463 , S4219 , H1737 , H3471

Condition Language
Sponsor failed to properly administer its CMS-approved formulary by applying unapproved utilization management practices.

Cause
Sponsor inappropriately limited new enrollees to no more than a 30 day supply on the initial dispensing of protected class medications with prior authorization or step therapy requirements.

Effect
A total of 57 enrollees were inappropriately denied coverage for medications at the point of sale. This resulted in enrollee payment out-of-pocket, delayed access to medication, or failure to receive medication.

CAP Submission 1

Project Completion Date: 9/1/2017

Org CAP Submission 1 - 8/28/2017 11:40 AM	CMS CAP Response 1 - 9/8/2017 10:25 AM
Remediation: While we believe the CMS-approved Transition Policy for 2017 (additional documentation, reference 13.1 and 5.1), submitted on 7/07/2016, allows for the 30 day limitation, overrides were placed within the RxClaim system from 01/01/2017-12/31/2017. Health Alliance has also prepared an acknowledgement letter to members explaining that we've placed an override through 12/31/17 and they can receive up to a 90 day supply of their medication. This letter will be cc'd to the prescriber and also include a DMR form. This letter will be sent prior to 09/01/2017. System/Operational Enhancements: An update to the RxClaim system has been made to remove the restriction of 30 days for new members to allow for the plan defined limit of protected class products. Daily monitoring of rejected claims will continue to ensure claims are processing accurately. During this monitoring, members of the pharmacy team ensure that claims are rejecting appropriately for UM and exception. This team also utilizes daily reports to ensure the transition policy and procedures are being accurately processed within the RxClaim system. Monthly monitoring of the Transition Process is also conducted and reported up through the Medicare Compliance Subcommittee.	Sponsor has summarized the issue and placed immediate corrections in the claims system to prevent the issue from recurring. The restriction has been removed from their claims system and daily monitoring is taking place to ensure it's not occurring. This CAP is accepted.

CAP Monitoring 1

Project Completion Date: 9/1/2017

Org CAP Submission 1 - 7/25/2018 12:09 PM	CMS CAP Response 1 - 7/25/2018 12:11 PM
No response required.	No response required.

Finding ID: 25470

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
25470	#2.05	Formulary Administration	CAR	CAP Released	12/5/2017	7/25/2018

Contract Number (s)
S4219 , H2591 , H1463 , H1737 , H3471

Condition Language
Sponsor failed to properly administer its CMS-approved formulary by applying unapproved quantity limits.

Cause
Sponsor inappropriately applied quantity limits to medications that do not have approved quantity limits.

Effect
This condition affected enrollees in two ways. First, three enrollees' were inappropriately denied coverage for two medications at the point of sale. This resulted in delayed access to medication. Second, 15 enrollees had authorizations which could have restricted access to four additional medications though none was experienced.

CAP Submission 1

Project Completion Date: 12/4/2017

Org CAP Submission 1 - 12/4/2017 2:58 PM	CMS CAP Response 1 - 12/5/2017 9:46 AM
Remediation: All improperly effectuated prior authorizations/exceptions have been updated to update quantity limits to adequately account for the 75% refill threshold. Health Alliance has also prepared an acknowledgement letter to members explaining that they can receive refills once the 75% threshold is reached for these drugs. This letter will be cc'd to the prescriber and also include a DMR form. This letter will be sent on 12/08/2017. System/Operational Enhancements: Because these were manual input errors, no system enhancement is needed. All improperly effectuated authorizations were updated within the system. Additional one-on-one training has occurred to specifically address the authorization input within the RxClaim system on 07/28/2017. Staff also received communication in writing regarding the proper authorization effectuation. Pharmacy Department Management has produced a training manual which has been distributed to all staff. This manual will also be used when training new staff. Daily monitoring of rejected claims will continue and include the review of all rejected claims that reject specifically for quantity limitations. Monthly monitoring to review rejected claims is also conducted and reported up through the Medicare Compliance Subcommittee.	Reviewed implemented changes and approve of steps to correct issue. CAP accepted.

CAP Monitoring 1

Project Completion Date: 12/4/2017

Org CAP Submission 1 - 7/25/2018 12:09 PM	CMS CAP Response 1 - 7/25/2018 12:11 PM
No response required.	No response required.

Finding ID: 25469

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
25469	#2.03	Formulary Administration	ICAR	CAP Released	9/8/2017	7/25/2018

Contract Number (s)
H2591 , H3471 , H1463 , H1737 , S4219

Condition Language
Sponsor improperly effectuated prior authorizations or exception requests.

Cause
Two root causes contributed to this condition. First, Sponsor effectuated quantity limit exception requests in a manner that limited access to a subsequent fill attempt. Second, Sponsor effectuated approved prior authorizations with a cost limit that prevented enrollees from receiving subsequent medication refills.

Effect
This condition affected enrollees in two ways. First, 45 enrollees were inappropriately denied coverage for 34 medications at the point of sale. This resulted in delayed access to medication. Second, 24 enrollees had authorizations which could have restricted access to six additional medications though none was experienced.

CAP Submission 1

Project Completion Date: 9/15/2017

Org CAP Submission 1 - 8/28/2017 11:40 AM	CMS CAP Response 1 - 9/8/2017 10:25 AM
Remediation: All improperly effectuated prior authorizations/exceptions have been updated to remove quantity limits and cost limits. Health Alliance has also prepared an acknowledgement letter to members explaining that they can receive these drugs without quantity/cost restrictions. This letter will be cc'd to the prescriber and also include a DMR form. This letter will be sent prior to 09/15/2017. System/Operational Enhancements: Because these were manual input errors, no system enhancement is needed. All improperly effectuated authorizations were removed from the system. Additional one-on-one training has occurred to specifically address the authorization input within the RxClaim system on 07/28/2017. Staff also received communication in writing regarding the proper authorization effectuation. Pharmacy Department Management is working to produce a training manual which will be distributed to all staff. This manual will also be used when training new staff. Daily monitoring of rejected claims will continue and include the review of all rejected claims that reject specifically for quantity and cost limitations. Monthly monitoring to review rejected claims is also conducted and reported up through the Medicare Compliance Subcommittee.	Sponsor made corrections and updates to remove limitations. Since this was a manual entry error cause, training is being provided. Daily monitoring of reviews will continue to ensure this isn't reoccurring. This CAP is accepted.

CAP Monitoring 1

Project Completion Date: 9/15/2017

Org CAP Submission 1 - 7/25/2018 12:09 PM	CMS CAP Response 1 - 7/25/2018 12:11 PM
No response required.	No response required.

Program Area: Part D Coverage Determinations, Appeals, and Grievances (CDAG)

Finding ID: 25487

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
25487	#3.40	Grievances and Misclassification of Requests	CAR	CAP Released	12/5/2017	7/25/2018

Contract Number (s)
H1463 , H1737 , H3471 , H2591 , S4219

Condition Language
Sponsor did not provide appropriate notifications of grievance resolutions.

Cause
Sponsor's case manager missed a step in the process outlined in Sponsor’s policies and procedures for grievance resolutions.

Effect
A total of two enrollees did not receive appropriate notifications of grievance resolutions. One enrollee who submitted a grievance in writing did not receive a written resolution notification, and one enrollee who submitted a quality of care grievance did not receive written notice of the right to file with the QIO or the QIO's contact information. Sponsor’s failure to provide appropriate notifications of grievance resolutions, including QIO information when applicable, resulted in an incomplete resolution of enrollees’ grievances.

CAP Submission 1

Project Completion Date: 12/4/2017

Org CAP Submission 1 - 12/4/2017 11:31 AM	CMS CAP Response 1 - 12/5/2017 12:29 PM
Upon review, a written response was not sent to the beneficiary in error (as a missed step in the process outlined in the Plan Policy 695). This has been rectified, and a written response with resolution was sent to the beneficiary on 7/19/17 and was postmarked 7/20/17. The complaint resolution team as well as the case owner has been educated on this process in order to eliminate this issue in future cases. Additionally, a review of all complaints will be completed by the complaint resolution team at a minimum bi-weekly, as well as monthly, to ensure all policies and guidance regarding grievances are followed appropriately. Adherence to grievance policy and proceudres are reported to the Medicare Compliance Subcommitee monthly. Upon initial review, the QIO letter was not sent to the beneficiary in error (as a missed step in the process outlined in the Plan Policy 695). This was immediately rectified, and a quality of care letter outlining the beneficiary's QIO rights was sent to the beneficiary as soon as it was identified. The complaint resolution team as well as the case owner has been educated on this process in order to eliminate this issue in future cases. Additionally, a review of all complaints will be completed by the complaint resolution team at a minimum bi-weekly, as well as monthly, to ensure all policies and guidance regarding grievances are followed appropriately. Adherence to grievance policy and proceudres are reported to the Medicare Compliance Subcommitee monthly. Upon reviewing the case and discovering the error on 7/10/17, the Plan immediately created and mailed a letter to the beneficiary outlining the beneficiary's QIO rights according to CMS chapter guidance regarding Quality of Care complaints. This letter was placed in the mail to the beneficiary on 7/10/2017 and was postmarked on 7/10/2017 at 3:30pm.	CAP accepted.

CAP Monitoring 1

Project Completion Date: 12/4/2017

Org CAP Submission 1 - 7/25/2018 12:21 PM	CMS CAP Response 1 - 7/25/2018 12:31 PM
No response required.	No response required.

Finding ID: 25472

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
25472	#3.26	Grievances and Misclassification of Requests	ICAR	CAP Released	9/6/2017	7/25/2018

Contract Number (s)
H3471 , H1463 , H2591 , S4219 , H1737

Condition Language
Sponsor misclassified coverage determination or redetermination requests as grievances and/or customer service inquiries.

Cause
Sponsor could not identify a root cause of this condition.

Effect
A total of four calls were non-compliant for misclassification of coverage determinations or redeterminations as customer service inquiries. Failure to treat coverage determination or redetermination requests as such delays enrollees access to medications and to the appeals process.

CAP Submission 1

Project Completion Date: 9/15/2017

Org CAP Submission 1 - 8/28/2017 11:45 AM	CMS CAP Response 1 - 8/31/2017 12:08 PM
Re-education to staff is being conducted continuously with a target date of 09/15/2017 for completion. A strong emphasis will be placed on proper usage of the call script when the enrollee is requesting a coverage determination. Monthly monitoring has been implemented. Results will be reviewed with staff and reported up to the Medicare Compliance Subcommittee.	Sponsor's remediation plan is insufficient. Please contact the four affected enrollees to confirm that they wanted a coverage determination and process for them as needed. Please provide confirmation in updated CAP submission by 9/6/2017 at 6:00 PM ET.

CAP Submission 2

Project Completion Date: 9/6/2017

Org CAP Submission 2 - 9/6/2017 5:06 PM	CMS CAP Response 2 - 9/6/2017 5:45 PM
Remediation: The Pharmacy staff will reach out to the enrollees of cases CL-4 and CL-6 to inquire if a determination is being requested by 9/6/2017. The determination process will be completed if applicable. Enrollee of case CL-7 has been processed. The enrollee was notified of the determination on 3/17/2017. Enrollee of case CL-8 has been processed. The enrollee was notified of the redetermination on 4/14/2017. Re-education to staff is being conducted continuously with a target date of 09/15/2017 for completion. A strong emphasis will be placed on proper usage of the call script when the enrollee is requesting a coverage determination. Monthly monitoring has been implemented. Results will be reviewed with staff and reported up to the Medicare Compliance Subcommittee.	Sponsor's remediation plan is sufficient.

CAP Submission 3

Project Completion Date: 9/6/2017

Org CAP Submission 3 - 9/7/2017 5:41 PM	CMS CAP Response 3 - 9/7/2017 5:42 PM
Remediation: The Pharmacy staff will reach out to the enrollees of cases CL-4 and CL-6 to inquire if a determination is being requested by 9/6/2017. The determination process will be completed if applicable. Enrollee of case CL-7 has been processed. The enrollee was notified of the determination on 3/17/2017. Enrollee of case CL-8 has been processed. The enrollee was notified of the redetermination on 4/14/2017. Re-education to staff is being conducted continuously with a target date of 09/15/2017 for completion. A strong emphasis will be placed on proper usage of the call script when the enrollee is requesting a coverage determination. Monthly monitoring has been implemented. Results will be reviewed with staff and reported up to the Medicare Compliance Subcommittee.	Sponsor's remediation plan is sufficient.

CAP Monitoring 1

Project Completion Date: 9/6/2017

Org CAP Submission 1 - 7/25/2018 12:21 PM	CMS CAP Response 1 - 7/25/2018 12:31 PM
No response required.	No response required.

Finding ID: 25486

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
25486	#3.25	Grievances and Misclassification of Requests	CAR	CAP Released	12/5/2017	7/25/2018

Contract Number (s)
H1737 , S4219 , H3471 , H1463 , H2591

Condition Language
Sponsor failed to identify and process enrollee complaints and disputes as grievances.

Cause
Sponsor’s call center staff lacked clear instruction and training to appropriately identify cases as grievances.

Effect
Seven enrollees were denied their right to file a grievance when they called to express dissatisfaction with the operations, activities, or behavior of Sponsor.

CAP Submission 1

Project Completion Date: 12/15/2017

Org CAP Submission 1 - 12/4/2017 2:10 PM	CMS CAP Response 1 - 12/5/2017 12:29 PM
Remediation: One of the enrollees has passed away. The other 6 enrollees will be contacted by 12/15/2017 and a grievance will be initiated. System/Operational Enhancements: Between the dates of 8/25/2017 and 9/15/2017 all staff underwent additional training to identify and process enrollee's complaints and disputes as grievances. Monthly monitoring has been implemented, and coaching is being provided ongoing to staff as new issues are identified. Additionally, the Medicare Compliance Auditor is assisting in review of calls weekly and discusses the outcomes with the Member Services Manager as needed.	CAP accepted.

CAP Monitoring 1

Project Completion Date: 12/15/2017

Org CAP Submission 1 - 7/25/2018 12:21 PM	CMS CAP Response 1 - 7/25/2018 12:31 PM
No response required.	No response required.

Finding ID: 25475

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
25475	#3.15	Timeliness	CAR	CAP Released	12/5/2017	7/25/2018

Contract Number (s)
H1463 , H3471 , H1737 , S4219 , H2591

Condition Language
Sponsor did not notify enrollees or their prescribers, as appropriate, of its decisions within 24 hours of receipt of expedited coverage determination requests, or, for exceptions requests, physician's or other prescribers' supporting statements.

Cause
Two root causes contributed to this condition. First, Sponsor did not properly toll exception requests. Second, Sponsor did not account for weekend and holiday schedules for mail collection.

Effect
Of the 183 expedited coverage determination cases evaluated, 12 cases were untimely for notification. Failure to provide timely notifications of expedited coverage determinations denies enrollees their rights to explanations of the Sponsor's decisions on their urgent requests, and may delay access to medications.

CAP Submission 1

Project Completion Date: 12/4/2017

Org CAP Submission 1 - 12/4/2017 2:59 PM	CMS CAP Response 1 - 12/5/2017 12:29 PM
Remediation: On 10/01/2017, Health Alliance implemented an additional mail pick up at 4:30 PM Monday through Friday which allows for written notification to hit the mail stream in a timely manner. On 10/21/2017, the Health Alliance Pharmacy Department implemented a weekend and holiday on-call rotation schedule to process expedited coverage determinations that come in after normal business hours. System/Operational Enhancements: Staff has been educated regarding the processing timeframes and additional training materials have been developed for this process. On 7/28/2017, additional one-on-one training occurred to specifically address coverage determination. Pharmacy Department Management has produced a training manual which has been distributed to all staff. This manual will also be used when training new staff. Monthly monitoring to ensure timeliness is conducted and reported up through the Medicare Compliance Subcommittee.	CAP accepted.

CAP Monitoring 1

Project Completion Date: 12/4/2017

Org CAP Submission 1 - 7/25/2018 12:21 PM	CMS CAP Response 1 - 7/25/2018 12:31 PM
No response required.	No response required.

Finding ID: 25476

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
25476	#3.12	Timeliness	ICAR	CAP Released	9/6/2017	7/25/2018

Contract Number (s)
H1737 , H2591 , H3471 , H1463 , S4219

Condition Language
Sponsor did not auto-forward coverage determinations and/or redeterminations (standard and/or expedited) that exceeded the CMS required timeframe to the Independent Review Entity (IRE) for review and disposition.

Cause
Three root causes contributed to this condition. First, Sponsor erroneously used dates from its rejected claims reports to track timeliness of cases instead of the actual receipt date. Second, Sponsor did not properly toll exception requests. Third, Sponsor did not account for weekend and holiday schedules for mail collection. As such, Sponsor did not recognize these cases were late and required auto-forwarding to the IRE.

Effect
Of the 26 cases evaluated, 23 cases were non-compliant for failure to be auto-forwarded to the IRE. Failure to auto-forward cases to the IRE denies enrollees review of their request by the IRE and causes delays in enrollees' access to needed medications.

CAP Submission 1

Project Completion Date: 7/28/2017

Org CAP Submission 1 - 8/28/2017 11:45 AM	CMS CAP Response 1 - 8/31/2017 12:08 PM
Remediation: Coverage Determination decisions were made shortly after the expiration of the timeframe and notification was sent to member and prescriber. Thus, no remediation is necessary. System/Operational Enhancements: Staff has been educated regarding the processing timeframes and additional training materials have been developed for this process. On 7/28/2017, additional one-on-one training occurred to specifically address coverage determination timeliness and auto-forwarding untimely determinations to the IRE. Staff also received communication in writing regarding the auto-forward process. Pharmacy Department Management is working to produce a training manual which will be distributed to all staff. This manual will also be used when training new staff. Monthly monitoring to ensure untimely reviews are properly forwarded to the IRE is conducted and reported up through the Medicare Compliance Subcommittee.	Sponsor's remediation plan is insufficient. Please forward the untimely coverage determination denial cases to the IRE. It is not necessary to forward the untimely approval cases to the IRE. Please provide confirmation in updated CAP submission by 9/6/2017 at 6:00 PM ET.

CAP Submission 2

Project Completion Date: 9/8/2017

Org CAP Submission 2 - 9/6/2017 4:26 PM	CMS CAP Response 2 - 9/6/2017 5:45 PM
Remediation: All untimely determinations that were denied and not forwarded to the IRE, will be forwarded to the IRE by end of business 09/08/2017. System/Operational Enhancements: Staff has been educated regarding the processing timeframes and additional training materials have been developed for this process. On 7/28/2017, additional one-on-one training occurred to specifically address coverage determination timeliness and auto-forwarding untimely determinations to the IRE. Staff also received communication in writing regarding the auto-forward process. Pharmacy Department Management is working to produce a training manual which will be distributed to all staff. This manual will also be used when training new staff. Monthly monitoring to ensure untimely reviews are properly forwarded to the IRE is conducted and reported up through the Medicare Compliance Subcommittee.	Sponsor's remediation plan is sufficient.

CAP Submission 3

Project Completion Date: 9/8/2017

Org CAP Submission 3 - 9/7/2017 5:41 PM	CMS CAP Response 3 - 9/7/2017 5:42 PM
Remediation: All untimely determinations that were denied and not forwarded to the IRE, will be forwarded to the IRE by end of business 09/08/2017. System/Operational Enhancements: Staff has been educated regarding the processing timeframes and additional training materials have been developed for this process. On 7/28/2017, additional one-on-one training occurred to specifically address coverage determination timeliness and auto-forwarding untimely determinations to the IRE. Staff also received communication in writing regarding the auto-forward process. Pharmacy Department Management is working to produce a training manual which will be distributed to all staff. This manual will also be used when training new staff. Monthly monitoring to ensure untimely reviews are properly forwarded to the IRE is conducted and reported up through the Medicare Compliance Subcommittee.	Sponsor's remediation plan is sufficient.

CAP Monitoring 1

Project Completion Date: 9/8/2017

Org CAP Submission 1 - 7/25/2018 12:21 PM	CMS CAP Response 1 - 7/25/2018 12:31 PM
No response required.	No response required.

Finding ID: 25474

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
25474	#3.06	Timeliness	CAR	CAP Released	12/5/2017	7/25/2018

Contract Number (s)
H3471 , H2591 , H1737 , S4219 , H1463

Condition Language
Sponsor did not effectuate determinations within 7 days of receipt of standard redetermination requests.

Cause
Sponsor used the incorrect receipt date for the redetermination request because it failed to treat incoming medical records from the provider, submitted in response to prior outreach attempts, as a written redetermination request.

Effect
Of the four redetermination approvals in the SRD universe, one case was untimely for effectuation. Failure to process and effectuate approvals within CMS timeframes delays enrollee access to needed medications.

CAP Submission 1

Project Completion Date: 11/20/2017

Org CAP Submission 1 - 12/4/2017 11:25 AM	CMS CAP Response 1 - 12/5/2017 12:29 PM
Remediation: Pharmacy staff have been educated to forward additional information received after a coverage determination was made to the Appeals staff. Appeals staff have been educated to start the appeals process upon receipt of additional information after a coverage determination has been made. System/Operational Enhancement: Health Alliance policy and procedure "Medicare Advantage - Redetermination Appeals Process for Medicare Part D (Prescription Benefit)" has been updated as of 11/20/2017. The policy reflects the process to trigger the appeals process once additional information is received after a coverage determination has been made and the additional information does not have to indicate "appeal" or "reconsideration". The appeals process is monitored monthly and reported up to the Medicare Compliance Subcommittee.	CAP accepted.

CAP Monitoring 1

Project Completion Date: 11/20/2017

Org CAP Submission 1 - 7/25/2018 12:21 PM	CMS CAP Response 1 - 7/25/2018 12:31 PM
No response required.	No response required.

Finding ID: 25490

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
25490	#3.01	Appropriateness of Clinical Decision-Making & Compliance with Processing Requirements	CAR	CAP Released	12/5/2017	7/25/2018

Contract Number (s)
H3471 , H1463 , H2591 , H1737 , S4219

Condition Language
Enrollees or, as applicable, prescribers, did not receive accurate approval letters or did not receive full explanations of conditions of approval.

Cause
Sponsor's PBM misinterpreted CMS guidance to allow the explanation of payment (EOP) to serve as approval notification because it included the Amount Submitted for Reimbursement, Amount Allowed, Patient Responsibility, and Reimbursement Due to enrollee.

Effect
A total of 18 enrollees received incomplete information about the conditions of their direct member reimbursement approvals. Failure to send approval letters with full explanations of conditions of approval denies enrollees their right to complete and accurate information about coverage determination decisions.

CAP Submission 1

Project Completion Date: 1/31/2018

Org CAP Submission 1 - 12/4/2017 2:14 PM	CMS CAP Response 1 - 12/5/2017 12:29 PM
System Enhancement: OptumRx will send an informational approval letter along with the Explanation of Payment for all DMR approvals beginning 01/31/2018. DMR approval letter template attached for consideration.	CAP accepted.

CAP Monitoring 1

Project Completion Date: 1/31/2018

Org CAP Submission 1 - 7/25/2018 12:21 PM	CMS CAP Response 1 - 7/25/2018 12:31 PM
No response required.	No response required.

Finding ID: 27434

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
27434		Timeliness	Observation	CAP Released	11/29/2017	7/25/2018

Observation Language
Sponsor failed to provide an accurate and usable universe on its first two submissions. The third submission resulted in acceptable universes (SCD, SCDER, ECD, ECDER).

CAP Submission 1

Project Completion Date:

Org CAP Submission 1 - 11/29/2017 4:02 PM	CMS CAP Response 1 - 11/29/2017 4:02 PM
No CAP Required	No CAP Required

CAP Monitoring 1

Project Completion Date:

Org CAP Submission 1 - 11/29/2017 4:03 PM	CMS CAP Response 1 - 11/29/2017 4:03 PM
No response required	No response required

CAP Monitoring 2

Project Completion Date:

Org CAP Submission 2 - 7/25/2018 12:21 PM	CMS CAP Response 2 - 7/25/2018 12:31 PM
No response required.	No response required.

Finding ID: 26146

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
26146		Appropriateness of Clinical Decision-Making & Compliance with Processing Requirements	Observation	CAP Released	11/29/2017	7/25/2018

Observation Language
Sponsor provided denial notifications that contained inaccurate information related to the specific conditions of the denial in two cases. The inaccurate information in the letters was due to manual errors by the intake coordinator who entered an incorrect medication strength in the Utilization Management system, and the medical director who manually added language from CMS-approved criteria that included a medication the enrollee had already tried and failed. These were considered non-systemic incidents relative to other compliant denial letters that were reviewed (CDM-04, CDM-37).

CAP Submission 1

Project Completion Date:

Org CAP Submission 1 - 11/29/2017 4:05 PM	CMS CAP Response 1 - 11/29/2017 4:05 PM
No CAP Required	No CAP Required

CAP Monitoring 1

Project Completion Date:

Org CAP Submission 1 - 11/29/2017 4:06 PM	CMS CAP Response 1 - 11/29/2017 4:07 PM
No response required	No response required

CAP Monitoring 2

Project Completion Date:

Org CAP Submission 2 - 7/25/2018 12:21 PM	CMS CAP Response 2 - 7/25/2018 12:31 PM
No response required.	No response required.

Program Area: Part C Organization Determinations, Appeals, and Grievances (ODAG)

Finding ID: 25536

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
25536	#4.64	Timeliness	CAR	CAP Released	12/6/2017	7/25/2018

Contract Number (s)
H1737 , H1463 , H3471 , H2591

Condition Language
Sponsor did not notify enrollees of resolutions of standard grievances within 30 days or as expeditiously as the enrollees' cases required.

Cause
Sponsor's grievance staff failed to follow established procedures to ensure grievances were addressed and resolutions were concluded timely.

Effect
Of the 29 cases evaluated, three cases were non-compliant for untimely enrollee notification of the grievance resolution.

CAP Submission 1

Project Completion Date: 12/4/2017

Org CAP Submission 1 - 12/4/2017 11:45 AM	CMS CAP Response 1 - 12/6/2017 2:57 PM
One case was not resolved timely due to the case being closed in error prior to reaching the resolution of the grievance. The two other cases were not resolved timely due to being assigned to 1 of 5 individuals who were responsible for addressing grievances as well as other Plan responsibilities. Remediation steps were taken, and in June 2017 a complaint resolution specialist (with manager back-up) was appointed to ensure timeliness standards are met. Additionally, a complaints team including the complaint specialist, manager, and director, review cases for appropriate timely processing of grievances at least monthly, but frequently bi-weekly. Grievances are monitored at least monthly and reported to the Medicare Compliance Subcommittee monthly.	CMS fully accepts the CAP as submitted.

CAP Monitoring 1

Project Completion Date: 12/4/2017

Org CAP Submission 1 - 7/25/2018 12:40 PM	CMS CAP Response 1 - 7/25/2018 12:46 PM
No response required.	No response required.

Finding ID: 25535

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
25535	#4.53	Timeliness	CAR	CAP Released	12/6/2017	7/25/2018

Contract Number (s)
H2591 , H1737 , H1463 , H3471

Condition Language
Sponsor did not render its determinations within 72 hours of receipt of expedited organization determination requests.

Cause
Sponsor failed to meet the expedited timeframe deadline in an effort to obtain necessary information to make an appropriate decision for the pre-service requests.

Effect
Of the 361 cases evaluated, 31 cases were non-compliant for failure to render a decision within 72 hours of receiving the request. Late determination causes delays in enrollees' access to urgently needed medical services and impairs enrollees' ability to initiate an appeal.

CAP Submission 1

Project Completion Date: 12/4/2017

Org CAP Submission 1 - 12/4/2017 11:53 AM	CMS CAP Response 1 - 12/6/2017 2:57 PM
Remediation: In April 2017, partnerships were created between the nursing and non-clinical staff to shorten the nurses' turnaround times for decision making. The non-clinical staff now assist with case research under the nurses' direction and assist with researching in-network provider options. June 7, 2017 through June 12, 2017 – Medical Management Department conducted audit preparation sessions. Timeliness of pre-service requests was discussed and education was conducted via the preparation sessions with staff. July 14, 2017 the Medical Management Department met to discuss the pre-service timely requirements following the results of the audit. The Medical Management Department utilizes a SupportPoint site to house process workflows and requirements. Timeliness is captured on a "UM PA Workflow" page. Monthly monitoring has been implemented. Patterns of non-compliance with timeliness will be appropriately addressed, including potential action plan development and disciplinary action. Performance coaches are conducting one-on-one trainings for any decisions outside timeframe requirements. System/Operational Enhancements: Health Alliance has partnered with eviCore to conduct additional expedited pre-service requests.	CMS fully accepts the CAP as submitted.

CAP Monitoring 1

Project Completion Date: 12/4/2017

Org CAP Submission 1 - 7/25/2018 12:40 PM	CMS CAP Response 1 - 7/25/2018 12:46 PM
No response required.	No response required.

Finding ID: 25529

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
25529	#4.39	Appropriateness of Clinical Decision-Making & Compliance with Processing Requirements	CAR	CAP Released	12/6/2017	7/25/2018

Contract Number (s)
H3471 , H2591 , H1463 , H1737

Condition Language
Sponsor did not include in its denial letters adequate rationales, correct/complete information specific to denials, or language easily understandable to enrollees.

Cause
Sponsor's denial letters contained manual errors due to lack of review and oversight within the appeals department.

Effect
A total of four enrollees received inaccurate denial letters. Inaccurate denial letters cause uncertainty about the appropriate steps in the organization determination process.

CAP Submission 1

Project Completion Date: 11/20/2017

Org CAP Submission 1 - 12/4/2017 11:52 AM	CMS CAP Response 1 - 12/6/2017 2:57 PM
Health Alliance corrected and mailed out the denial letters to the four affected enrollees. A cover letter was attached explaining the clarification of the denial. Appeals staff were educated at the time of the CMS Program Audit finding and again on 11/20/2017 of the importance of clear and accurate denial letters. The Appeals process is monitored monthly and reported monthly to the Medicare Compliance Subcommittee.	CMS fully accepts the CAP as submitted.

CAP Monitoring 1

Project Completion Date: 11/20/2017

Org CAP Submission 1 - 7/25/2018 12:40 PM	CMS CAP Response 1 - 7/25/2018 12:46 PM
No response required.	No response required.

Finding ID: 25530

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
25530	#4.33	Grievances and Misclassification of Requests	CAR	CAP Released	12/6/2017	7/25/2018

Contract Number (s)
H1463 , H2591 , H3471 , H1737

Condition Language
Sponsor failed to provide enrollees quality of care grievance resolution letters that include their right to file with, and the contact information for, the Quality Improvement Organization (QIO).

Cause
Sponsor lacked training and oversight on its policies and procedures related to processing quality of care grievances.

Effect
A total of one enrollee did not receive QIO rights within their grievance resolution. Failure to inform the enrollee of their right to file a complaint with the QIO can prevent further investigation and resolution of the enrollee's quality of care concerns.

CAP Submission 1

Project Completion Date: 12/4/2017

Org CAP Submission 1 - 12/4/2017 11:51 AM	CMS CAP Response 1 - 12/6/2017 2:57 PM
Upon initial review, the QIO letter was not sent to the beneficiary in error (as a missed step in the process outlined in the Plan Policy 695). This was immediately rectified, and a quality of care letter outlining the beneficiary's QIO rights was sent to the beneficiary as soon as it was identified. The complaint resolution team as well as the case owner have been educated on this process in order to eliminate this issue in future cases. Additionally, a review of all complaints will be completed by the complaint resolution team at a minimum bi-weekly, as well as monthly, to ensure all policies and guidance regarding grievances are followed appropriately. Adherence to grievance policy and procedures are reported to the Medicare Compliance Subcommittee monthly. Upon reviewing the case and discovering the error on 7/12/17, the Plan immediately created and mailed a letter to the beneficiary outlining the beneficiary's QIO rights according to CMS chapter guidance regarding Quality of Care complaints. This letter was placed in the mail to the beneficiary on 7/12/2017 and was postmarked on 7/12/2017 at 11:45am. The complaint resolution team as well as the case owner have been educated on this process in order to eliminate this issue in future cases. Additionally, a review of all complaints will be completed by the complaint resolution team at a minimum bi-weekly, as well as monthly, to ensure all policies and guidance regarding grievances are followed appropriately. Adherence to grievance policy and procedures are reported to the Medicare Compliance Subcommittee monthly.	CMS fully accepts the CAP as submitted.

CAP Monitoring 1

Project Completion Date: 12/4/2017

Org CAP Submission 1 - 7/25/2018 12:40 PM	CMS CAP Response 1 - 7/25/2018 12:46 PM
No response required.	No response required.

Finding ID: 25533

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
25533	#4.09	Timeliness	ICAR	CAP Released	9/1/2017	7/25/2018

Contract Number (s)
H1737 , H2591 , H1463 , H3471

Condition Language
Sponsor did not notify enrollees, and providers if the providers requested the service, of its decisions within 14 calendar days of receipt of standard organization determination requests.

Cause
Two root causes contributed to this condition. First, Sponsor’s process was to notify the provider of approved pre-service requests and Sponsor expected the provider to notify the enrollee of the approval. Second, Sponsor entered approval letters in the enrollee portal, but could not determine whether the enrollee accessed the notification timely.

Effect
Of the 7,813 cases evaluated, 1,800 cases were non-compliant for failure to notify enrollees of its decision timely. Late notification causes delays in enrollees' access to needed medical services.

CAP Submission 1

Project Completion Date: 9/15/2017

Org CAP Submission 1 - 8/28/2017 11:49 AM	CMS CAP Response 1 - 9/1/2017 11:14 AM
Remediation: We conducted a thorough review of member impact to identify issues with enrollee access. Of the 1,800 non-compliant cases, 1,683 enrollees did not receive notification. We identified 1,436 enrollees with a pre-service request who had an associated claim (no access to care issue). We identified 247 enrollees with a pre-service requests with no associated claim. We are conducting outreach to the 247 enrollees via phone call with a target completion date of 9/15/2017. June 7, 2017 through June 12, 2017 – Medical Management Department conducted audit preparation sessions. Timeliness of pre-service requests was discussed and education was conducted via the preparation sessions with staff. July 14, 2017 the Medical Management Department met to discuss the pre-service timely requirements following the results of the audit. Monthly monitoring has been implemented. Performance coaches are conducting one-on-one trainings for any notifications outside timeframe requirements. System/Operational Enhancements: Health Alliance has partnered with eviCore to conduct additional pre-service requests. As of May 18, 2017 the Medical Management Department began notifying enrollees of all determinations.	CMS finds the information contained in the CAP acceptable.

CAP Monitoring 1

Project Completion Date: 9/15/2017

Org CAP Submission 1 - 7/25/2018 12:40 PM	CMS CAP Response 1 - 7/25/2018 12:46 PM
No response required.	No response required.

Finding ID: 25511

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
25511	#4.01	Timeliness	ICAR	CAP Released	9/1/2017	7/25/2018

Contract Number (s)
H3471 , H1463 , H2591 , H1737

Condition Language
Sponsor did not notify enrollees, and providers if the providers requested the services, of its decisions within 72 hours of receipt of expedited organization determination requests.

Cause
Two root causes contributed to this condition. First, Sponsor’s process was to notify the provider of approved pre-service requests and Sponsor expected the provider to notify the enrollee of the approval. Second, Sponsor entered approval letters in the enrollee portal, but could not determine whether the enrollee accessed the notification timely.

Effect
Of the 361 cases evaluated, 180 cases were non-compliant for failure to notify enrollees of its decision timely. Late notification causes delays in enrollees' access to needed medical services.

CAP Submission 1

Project Completion Date: 9/15/2017

Org CAP Submission 1 - 8/28/2017 11:49 AM	CMS CAP Response 1 - 9/1/2017 11:14 AM
Remediation: We conducted a thorough review of member impact to identify issues with enrollee access. Of the 180 non-compliant cases, 162 enrollees did not receive a notification of the determination. We identified 122 enrollees with a pre-service request who had an associated claim (no access to care issue). We identified 40 pre-service requests with no associated claim. We are conducting outreach to the 122 enrollees via phone call with a target completion date of 9/15/2017. June 7, 2017 through June 12, 2017 – Medical Management Department conducted audit preparation sessions. Timeliness of pre-service requests was discussed and education was conducted via the preparation sessions with staff. July 14, 2017 the Medical Management Department met to discuss the pre-service timely requirements following the results of the audit. Monthly monitoring has been implemented. Performance coaches are conducting one-on-one trainings for any notifications outside timeframe requirements. System/Operational Enhancements: Health Alliance has partnered with eviCore to conduct additional pre-service requests. As of May 18, 2017 the Medical Management Department began notifying enrollees of all determinations.	CMS finds the information contained in the CAP acceptable.

CAP Monitoring 1

Project Completion Date: 9/15/2017

Org CAP Submission 1 - 7/25/2018 12:40 PM	CMS CAP Response 1 - 7/25/2018 12:46 PM
No response required.	No response required.

Corrective Action Plan (CAP) Detail Report

CAP Report Search Parameters: **Program Area** = All **Finding Type** = All **CAP Phase** = All **Finding ID** = All **Element** = All

Audit ID	Parent Organization	Exit Conference Date	Entire CAP Accept Date	Entire CAP Release Date
8409	Centene Corporation	6/25/2021	12/9/2021	1/23/2023

Program Area: Compliance Program Effectiveness (CPE)

Finding ID: 40422

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
40422	#1.12	Prevention Controls and Activities	CAR	CAP Released	12/8/2021	1/23/2023

Contract Number (s)
H1112 , H2491 , H4699 , H5590 , H6348 , H6439 , H6713 , H6975 , H7323 , H8711 , H9630 , S5768 , H0029 , H0062 , H0351 , H0480 , H0562 , H0913 , H1032 , H1436 , H5087 , H5190 , H5779 , H6830 , H7173 , S4802 , H1664 , H1723 , H1862 , H2174 , H5965 , H8189 , H9258 , H0074 , H1353 , H3499 , H4847 , H5439 , H6594 , H7518 , H7925 , H0174 , H0270 , H0908 , H1774 , H1914 , H3561 , H4343 , H5117 , H5199 , H5475 , H5656 , H8225 , H9335 , H9811 , H0111 , H0482 , H2162 , H3047 , H4868 , H5398 , H5599 , H6550 , H7399 , S5810 , H0022 , H0712 , H0969 , H1416 , H2134 , H2853 , H5294 , H5430 , H6080 , H6870 , H7326 , H9364 , H9428 , H0088 , H0724 , H1848 , H2775 , H2915 , H3237 , H3975 , H4506 , H6446 , H6815 , H7175 , H8553 , H9276 , H9387 , H9487 , H9730

Condition Language
Sponsor did not establish and implement training and education for its compliance officer and organization employees, the MA/PD organization's chief executive and other senior administrators, managers and governing body members.

Cause
Sponsor lacked a process to ensure hiring managers assigned required compliance and fraud, waste, and abuse (FWA) training to temporary employees as part of the new employee orientation.

Effect
Sponsor identified 38 temporary employees that did not receive Medicare compliance or FWA training as part of the orientation for new employees.

CAP Submission 1

Project Completion Date: 2/1/2022

(b)(4)

CAP is acceptable.

CAP Monitoring 1

Project Completion Date: 2/1/2022

Org CAP Submission 1 - 1/23/2023 3:08 PM	CMS CAP Response 1 - 1/23/2023 3:09 PM
No response required.	No response required.

CAP Monitoring 2

Project Completion Date: 2/1/2022

Org CAP Submission 2 - 1/23/2023 3:10 PM	CMS CAP Response 2 - 1/23/2023 3:11 PM
No response required.	No response required.

Program Area: Part D Formulary and Benefit Administration (FA)

Finding ID: 40345

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
40345	#2.22	Transition	CAR	CAP Released	12/8/2021	1/23/2023

Contract Number (s)
H6080 , H0480

Condition Language
Sponsor failed to properly administer the CMS transition policy.

Cause
Sponsor lacked a process to notify prescribers of enrollee transition fills when it did not have the prescribers' fax number on file.

Effect
Sponsor identified 3,897 transition notifications were not provided to prescribers for 2,078 enrollees.

CAP Submission 1

Project Completion Date: 1/1/2022

	CMS CAP Response 1 - 12/9/2021 11:47 AM
(b)(4) 3. Effective 1/1/2022 the impacted contracts will be migrating from the Meridian pharmacy claims system, MERLIN, to the CVS Caremark pharmacy claims system, RxClaim. Monitoring and oversight processes exist to ensure that all member and prescriber transition letters are sent within the required timeframe by CVS Caremark. TF letters for these contracts will automatically roll into that process beginning on 1/1/2022.	CMS accepts the CAP.

CAP Monitoring 1

Project Completion Date: 1/1/2022

Org CAP Submission 1 - 1/23/2023 3:15 PM	CMS CAP Response 1 - 1/23/2023 3:23 PM
No response required.	No response required.

Finding ID: 40346

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
40346	#2.19	Transition	CAR	CAP Released	12/8/2021	1/23/2023

Contract Number (s)
H0022 , H0351 , H1774 , H2491 , H3499 , H5475 , H6348 , H0074 , H0111 , H0482 , H1032 , H1664 , H1723 , H5439 , H6080 , H6870 , H8189 , H9258 , H9730 , H1112 , H1436 , H1848 , H1914 , H2915 , H4506 , H4847 , H5398 , H6550 , H6815 , H6830 , H7173 , H8711 , H9276 , H9630 , H1862 , H2134 , H4343 , H5590 , H7323 , H7925 , H9335 , H9387 , H9487 , H9811 , S4802 , H0029 , H0480 , H0724 , H1353 , H2162 , H2775 , H4699 , H5199 , H5294 , H5656 , H5965 , H6975 , H7326 , H7518 , H0174 , H0270 , H1416 , H2853 , H3237 , H5087 , H5599 , H5779 , H6594 , H6713 , H7175 , S5768 , H0062 , H0712 , H0908 , H0969 , H3047 , H3975 , H5117 , H5190 , H7399 , H8225 , H8553 , H9428 , S5810 , H0088 , H0562 , H0913 , H2174 , H3561 , H4868 , H5430 , H6439 , H6446 , H9364

Condition Language
Sponsor failed to provide continuing enrollees transition supplies of non-formulary medications.

Cause
Sponsor inappropriately applied medically-accepted indication (MAI) edits on transition-eligible medications for continuing enrollees with previously approved authorizations due to its system's inability to capture previously documented Part D MAIs.

Effect
Sponsor identified 51 enrollees that were inappropriately denied coverage for six medications at the point of sale. This resulted in delayed access to medications, paying out of pocket for medications, or failure to receive medications.

CAP Submission 1

Project Completion Date: 12/31/2021

(b)(4)	CMS accepts the CAP.

CAP Monitoring 1

Project Completion Date: 12/31/2021

Org CAP Submission 1 - 1/23/2023 3:15 PM	CMS CAP Response 1 - 1/23/2023 3:23 PM
No response required.	No response required.

Finding ID: 40586

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
40586	#2.05	Formulary Administration	CAR	CAP Released	12/8/2021	1/23/2023

Contract Number (s)
H6080 , H0480

Condition Language
Sponsor failed to properly administer its CMS-approved formulary by applying unapproved quantity limits.

Cause
Sponsor incorrectly configured its system to apply a daily dose quantity limit calculation logic to formulary medications with CMS-approved quantity over time edits.

Effect
Sponsor identified nine enrollees that were inappropriately denied coverage for nine medications at the point of sale. This resulted in delayed access to medications, paying out of pocket for medications, or failure to receive medication.

CAP Submission 1

Project Completion Date: 1/1/2022

(b)(4)	CMS accepts the CAP.

CAP Monitoring 1

Project Completion Date: 1/1/2022

Org CAP Submission 1 - 1/23/2023 3:15 PM	CMS CAP Response 1 - 1/23/2023 3:23 PM
No response required.	No response required.

Finding ID: 41471

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
41471	#2.38	Formulary Administration	Observation	CAP Released	12/8/2021	1/23/2023

Observation Language
Sponsor inappropriately denied 20 medications at point of sale for two enrollees due to incorrect configuration of the enrollment data transfer system and failure to process enrollment/disenrollment transactions received at the same time in the correct order. This observation requires correction and submission of a corrective action plan (FA PC 2, FA PC 3, FA PC 2 Case File.pdf, FA PC 3 Case File.pdf, FA PC 3 Enrollment Reject Narrative.pdf, Centene FA Beneficiary Enrollment Impact Analysis.xlsx, Centene Enrollment Transaction Impact Analysis.xlsx).

CAP Submission 1

Project Completion Date: 1/15/2022

Org CAP Submission 1 - 12/2/2021 1:07 PM	CMS CAP Response 1 - 12/9/2021 11:47 AM
1. WellCare's enrollment intake process: The member's eligibility was resolved on 4/21/21. (b)(4)	CMS approves the CAP.

CAP Monitoring 1

Project Completion Date: 1/15/2022

Org CAP Submission 1 - 1/23/2023 3:15 PM	CMS CAP Response 1 - 1/23/2023 3:23 PM
No response required.	No response required.

Program Area: Part D Coverage Determinations, Appeals, and Grievances (CDAG)

Finding ID: 40870

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
40870	#3.22	Appropriateness of Clinical Decision-Making & Compliance with Processing Requirements	ICAR	CAP Released	8/16/2021	1/23/2023

Contract Number (s)
H3561 , H5439 , H1723 , H0174 , H0913 , H2775 , H6815 , S5810 , H6870 , S5768 , H1112 , H0351 , H0562 , H9630 , S4802

Condition Language
Sponsor made inappropriate denials when processing coverage requests.

Cause
Two root causes contributed to this condition. First, Sponsor's process did not direct clinical reviewers to consider CMS-approved compendia for a medically accepted indication within the National Comprehensive Cancer Network guidelines. Second, Sponsor's process for reviewing redetermination requests did not include outreach to determine if the requestor was seeking an exception to the prior authorization criteria or was seeking to satisfy the prior authorization requirement. Additionally, in nine requests for medications associated with end-stage renal dialysis and dry eyes, Sponsor did not review all medical records and did not consider all diagnoses.

Effect
Sponsor identified 131 enrollees who received denials in which clinical information was not considered.

CAP Submission 1

Project Completion Date: 8/3/2021

(b)(4)

CAP Submission 2

Project Completion Date: 8/20/2021

(b)(4)	CAP is acceptable.

CAP Monitoring 1

Project Completion Date: 8/20/2021

Org CAP Submission 1 - 1/23/2023 3:24 PM	CMS CAP Response 1 - 1/23/2023 3:25 PM
No response required.	No response required.

CAP Monitoring 2

Project Completion Date: 8/20/2021

Org CAP Submission 2 - 1/23/2023 3:26 PM	CMS CAP Response 2 - 1/23/2023 3:27 PM
No response required.	No response required.

Program Area: Part C Organization Determinations, Appeals, and Grievances (ODAG)

Finding ID: 40352

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
40352	#4.96	Timeliness	CAR	CAP Released	12/8/2021	1/23/2023

Contract Number (s)
H1112 , H1723 , H1862 , H5590 , H5965 , H6594 , H6713 , H0029 , H0111 , H0724 , H1914 , H3975 , H6080 , H6446 , H6870 , H6975 , H7175 , H7323 , H8553 , H9387 , H9487 , H0562 , H0913 , H1848 , H2174 , H3561 , H4506 , H5398 , H6348 , H7518 , H8225 , H8711 , H9730 , H0174 , H0270 , H1353 , H1436 , H2491 , H4847 , H4868 , H5475 , H5656 , H6439 , H6830 , H8189 , H9630 , H0074 , H0088 , H0351 , H0712 , H0908 , H2915 , H5779 , H6550 , H7173 , H7399 , H7925 , H9276 , H0062 , H1032 , H1774 , H2853 , H4343 , H5117 , H5199 , H5439 , H5599 , H6815 , H9335 , H9428 , H0022 , H0480 , H1416 , H1664 , H2134 , H2162 , H3237 , H3499 , H4699 , H5430 , H9364 , H9811 , H0482 , H0969 , H2775 , H3047 , H5087 , H5190 , H5294 , H7326 , H9258

Condition Language
Sponsor failed to pay or deny enrollee submitted claims within 60 days of receipt of payment requests.

Cause
Sponsor customer service staff incorrectly routed claims to its medical team for review, creating an influx of cases the team was not prepared to process.

Effect
Of the 917 cases evaluated, 75 cases were noncompliant for late notification of payment denials or late effectuation of payment approvals.

CAP Submission 1

Project Completion Date: 11/1/2021

(b)(4)	CAP is acceptable.

CAP Monitoring 1

Project Completion Date: 11/1/2021

Org CAP Submission 1 - 1/23/2023 3:33 PM	CMS CAP Response 1 - 1/23/2023 3:37 PM
No response required.	No response required.

Finding ID: 40356

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
40356	#4.37	Appropriateness of Clinical Decision-Making & Compliance with Processing Requirements	CAR	CAP Released	12/8/2021	1/23/2023

Contract Number (s)
H0482 , H0969 , H1032 , H1353 , H1774 , H2775 , H5475 , H5779 , H6446 , H7173 , H8553 , H9428 , H0174 , H0712 , H1862 , H3237 , H4343 , H5117 , H5398 , H5599 , H5965 , H6870 , H7175 , H7326 , H8225 , H9487 , H0029 , H0480 , H0562 , H0724 , H1112 , H2134 , H3975 , H5190 , H5590 , H6594 , H9258 , H9335 , H9364 , H9811 , H0913 , H1436 , H1723 , H3047 , H3499 , H4699 , H5430 , H6439 , H6713 , H6830 , H7399 , H9276 , H9387 , H0062 , H1416 , H1914 , H2162 , H2174 , H2491 , H2853 , H3561 , H4506 , H4868 , H5294 , H5439 , H6815 , H5199 , H7925 , H8189 , H8711 , H0111 , H0351 , H2915 , H6975 , H7323 , H7518 , H0022 , H0074 , H0088 , H0270 , H0908 , H1664 , H1848 , H4847 , H5087 , H5656 , H6080 , H6348 , H6550 , H9630 , H9730

Condition Language
Sponsor did not notify enrollees in writing of the reason for the delay, and their right to file an expedited grievance, when Sponsor granted itself extensions to processing timeframes for standard or expedited pre-service organization determinations and/or reconsideration requests.

Cause
Sponsor staff did not follow established procedures for extensions. Additionally, Sponsor did not have a quality review process to ensure that extension notifications were sent to enrollees.

Effect
Sponsor identified 59 enrollees that did not receive a notification when Sponsor granted itself an extension to the reconsideration processing timeframe.

CAP Submission 1

Project Completion Date: 12/31/2021

	CMS CAP Response 1 - 12/9/2021 11:48 AM
(b)(4)	CAP is acceptable.

CAP Monitoring 1

Project Completion Date: 12/31/2021

Org CAP Submission 1 - 1/23/2023 3:33 PM	CMS CAP Response 1 - 1/23/2023 3:37 PM
No response required.	No response required.

Finding ID: 40353

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
40353	#4.16	Timeliness	CAR	CAP Released	12/8/2021	1/23/2023

Contract Number (s)
H0174 , H1664 , H1848 , H1914 , H3047 , H5430 , H6080 , H8225 , H0062 , H0480 , H4699 , H5117 , H6975 , H8553 , H8711 , H9387 , H9487 , H0913 , H1353 , H2174 , H3237 , H4343 , H4847 , H5398 , H5656 , H6594 , H7323 , H9335 , H9364 , H0074 , H0088 , H0969 , H1436 , H1862 , H4506 , H5087 , H5190 , H6713 , H6830 , H7326 , H9630 , H9811 , H0022 , H1723 , H1774 , H5779 , H6439 , H0270 , H0908 , H1112 , H2491 , H2853 , H3975 , H5199 , H7175 , H7518 , H7925 , H8189 , H9258 , H0111 , H0482 , H0712 , H1032 , H2162 , H3499 , H3561 , H6348 , H6446 , H6815 , H7173 , H7399 , H9730 , H0029 , H0351 , H0562 , H0724 , H1416 , H2134 , H2775 , H2915 , H4868 , H5294 , H5439 , H5475 , H5590 , H5965 , H6550 , H6870 , H9276 , H9428

Condition Language
Sponsor failed to notify enrollees of its favorable standard pre-service reconsidered decisions, or to auto-forward its upheld adverse decisions to the IRE, within 30 days, plus extension (if applicable).

Cause
Two root causes contributed to this condition. First, Sponsor’s inventory reporting did not include timeliness metrics to assist in ensuring reconsiderations were closed timely. Second, Sponsor's delegated entities did not follow established procedures for timely processing of reconsiderations.

Effect
Of the 543 cases evaluated, 51 cases were noncompliant for late notification or auto-forwarding of standard pre-service reconsideration decisions.

CAP Submission 1

Project Completion Date: 3/15/2022

CAP is acceptable.

(b)(4)

(b)(4)

(b)(4)

CAP Monitoring 1

Project Completion Date: 3/15/2022

Org CAP Submission 1 - 1/23/2023 3:33 PM	CMS CAP Response 1 - 1/23/2023 3:37 PM
No response required.	No response required.

Finding ID: 40355

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
40355	#4.15	Timeliness	CAR	CAP Released	12/8/2021	1/23/2023

Contract Number (s)
H0351 , H3975 , H5294 , H5398 , H6348 , H7326 , H0022 , H0029 , H0088 , H0174 , H1416 , H1436 , H2491 , H2915 , H4868 , H5087 , H5599 , H5779 , H6594 , H7173 , H9276 , H9364 , H9730 , H0111 , H0562 , H0969 , H1848 , H2174 , H5117 , H6830 , H7323 , H9487 , H0724 , H0913 , H3237 , H3561 , H4847 , H6815 , H6975 , H9428 , H9811 , H0074 , H2134 , H2162 , H5199 , H5439 , H5656 , H9387 , H0062 , H0482 , H0712 , H0908 , H1032 , H1112 , H1723 , H2775 , H2853 , H4506 , H5190 , H5430 , H6550 , H7175 , H7925 , H8225 , H8553 , H8711 , H9258 , H0270 , H1914 , H4343 , H4699 , H5590 , H6439 , H7399 , H7518 , H8189 , H9335 , H0480 , H1353 , H1664 , H1774 , H1862 , H3047 , H3499 , H5475 , H5965 , H6080 , H6446 , H6713 , H6870 , H9630

Condition Language
Sponsor failed to pay non-contract provider claims, or to auto-forward its upheld adverse decisions to the IRE, within 60 days of receipt of payment reconsideration requests.

Cause
Sponsor’s inventory reporting did not include timeliness metrics to assist in ensuring payment reconsiderations received from non-contract providers were closed timely.

Effect
Of the 941 cases evaluated, 189 cases were noncompliant for late auto-forwarding of noncontract payment reconsideration denials to the IRE or late effectuation of approved noncontract payment reconsiderations.

CAP Submission 1

Project Completion Date: 10/5/2021

(b)(4)	AP is acceptable.

CAP Monitoring 1

Project Completion Date: 10/5/2021

Org CAP Submission 1 - 1/23/2023 3:33 PM	CMS CAP Response 1 - 1/23/2023 3:37 PM
No response required.	No response required.

Finding ID: 40354

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
40354	#4.02	Timeliness	CAR	CAP Released	12/8/2021	1/23/2023

Contract Number (s)
H0074 , H0270 , H1723 , H5199 , H5965 , H6446 , H8225 , H0480 , H0482 , H1664 , H2134 , H2491 , H2915 , H4506 , H5779 , H7399 , H9258 , H9276 , H9630 , H0022 , H1112 , H1436 , H1774 , H2775 , H3975 , H4699 , H5590 , H5656 , H6439 , H7326 , H9811 , H0029 , H0174 , H0562 , H0724 , H1353 , H1416 , H1862 , H2853 , H5087 , H6080 , H6830 , H7518 , H9364 , H0351 , H0712 , H3237 , H3499 , H5190 , H5430 , H5439 , H6348 , H6975 , H7175 , H7925 , H8553 , H8711 , H0088 , H0111 , H0908 , H0913 , H0969 , H1914 , H2174 , H4343 , H4847 , H4868 , H5294 , H5475 , H6550 , H9335 , H9387 , H0062 , H1848 , H2162 , H6870 , H7323 , H8189 , H9428 , H9487 , H9730 , H1032 , H3047 , H3561 , H5117 , H5398 , H5599 , H6594 , H6713 , H6815 , H7173

Condition Language
Sponsor failed to notify enrollees of its favorable expedited pre-service reconsidered decisions within 72 hours, plus extension (if applicable), or to auto-forward its upheld adverse decisions to the IRE within 24 hours of affirming its decision.

Cause
Two root causes contributed to this condition. First, Sponsor’s inventory reporting did not include timeliness metrics to assist in ensuring reconsiderations were closed timely. Second, Sponsor's delegated entities did not follow established procedures for timely processing of reconsiderations.

Effect
Of the 744 cases evaluated, 80 cases were noncompliant for late notification of coverage decisions for expedited pre-service reconsideration requests.

CAP Submission 1

Project Completion Date: 12/31/2021

(b)(4)

CAP is acceptable.

(b)(4)

CAP Monitoring 1

Project Completion Date: 12/31/2021

Org CAP Submission 1 - 1/23/2023 3:33 PM	CMS CAP Response 1 - 1/23/2023 3:37 PM
No response required.	No response required.

Program Area: Special Needs Plans - Model of Care (SNP-MOC)

Finding ID: 40863

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
40863	#5.55	Care Coordination	Observation	CAP Released	12/8/2021	1/23/2023

Observation Language
Sponsor did not complete outreach for 16 enrollees upon notification of a discharge, in accordance with the MOC, due to a lack of communication of discharges between the Case Management and Inpatient departments. This observation requires correction and submission of a corrective action plan (SNP-5, Centene_SNP_Transition of Care IA.xlsx).

CAP Submission 1

Project Completion Date: 11/30/2021

Org CAP Submission 1 - 12/2/2021 1:09 PM	CMS CAP Response 1 - 12/9/2021 11:48 AM
1. Delegated provider group Heath Care LA (HCLA) Care Managers (CM) conducted outreach to the 16 impacted members (beneficiaries) and updated the member's case files. 2. HCLA Care Managers developed a daily TOC report, roles and responsibilities, and workflow/job aids. Note. When audit findings are identified in regards to TOC, CAPs are created and discussed with the HN CM Team. If issues continue to occur, escalation to management is done, as needed. 3. HCLA Case Managers and Case Coordinators completed refresher training on TOC guidelines. Note: Any new CM hires are required to complete all case management trainings as a part of their onboarding orientation. (b)(4)	CAP is acceptable.

CAP Monitoring 1

Project Completion Date: 11/30/2021

Org CAP Submission 1 - 1/23/2023 3:40 PM	CMS CAP Response 1 - 1/23/2023 3:41 PM
No response required.	No response required.

Finding ID: 40862

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
40862	#5.42	Care Coordination	Observation	CAP Released	12/8/2021	1/23/2023

Observation Language
Sponsor Interdisciplinary Care Teams (ICTs) did not include a Care Manager for 16,603 enrollees due to inconsistencies in it MOC requirements for ICT composition for low risk enrollees. Sponsor's MOC states that the core members of the ICT includes a Care Manager but subsequently states that low risk enrollees are continuously monitored but not engaged with a Care Manager. This observation requires correction and submission of a corrective action plan (SNP-7, SNP-8, SNP-10, SNP-11, SNP-14, and SNP-ALT3, Centene_SNP_Missing Care Manager IA.xlsx).

CAP Submission 1

Project Completion Date: 9/30/2021

(b)(4) (b)(4)	CAP is acceptable.

CAP Monitoring 1

Project Completion Date: 9/30/2021

Org CAP Submission 1 - 1/23/2023 3:40 PM	CMS CAP Response 1 - 1/23/2023 3:41 PM
No response required.	No response required.

Program Area: Medicare Medicaid Plan - Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)

Finding ID: 40379

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
40379	#7.97	Timeliness	CAR	CAP Released	12/8/2021	1/23/2023

Contract Number (s)
H3237 , H6080 , H6870 , H0022 , H0480 , H1723 , H9487

Condition Language
Sponsor did not notify enrollees of its expedited service authorization request decisions timely.

Cause
Sponsor's system was not appropriately configured to send approval notifications to enrollees for home and community based services. Additionally, some notifications were untimely due to staff failing to follow established processes for mailing notifications at the conclusion of the Sponsor’s decisions.

Effect
Of the 177 cases evaluated for the Texas contract, 13 cases were non-compliant for late notification of coverage decisions for MMP expedited service authorization requests. Of the 137 cases evaluated for the Illinois contract, 10 cases were non-compliant for late notification of coverage decisions for MMP expedited service authorization requests. Of the 189 cases evaluated for the Ohio contract, eight cases were non-compliant for late notification of coverage decisions for MMP expedited service authorization requests. Of the 627 cases evaluated for the California contract, 21 cases were non-compliant for late notification of coverage decisions for MMP expedited service authorization requests. Of the 129 cases evaluated for the Michigan contract, four cases were non-compliant for late notification of coverage decisions for MMP expedited service authorization requests. Of the 45 cases evaluated for the South Carolina contract, one case was non-compliant for late notification of a coverage decision for MMP expedited service authorization requests. In total, of the 1,304 cases evaluated, 57 cases were noncompliant for late notification of expedited service authorization requests.

CAP Submission 1

Project Completion Date: 10/12/2021

Org CAP Submission 1 - 12/2/2021 4:52 PM	CMS CAP Response 1 - 12/9/2021 11:59 AM
(b)(4)	CAP is acceptable.

CAP Monitoring 1

Project Completion Date: 10/12/2021

Org CAP Submission 1 - 1/23/2023 3:45 PM	CMS CAP Response 1 - 1/23/2023 3:47 PM
No response required.	No response required.

Finding ID: 40377

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
40377	#7.96	Timeliness	ICAR	CAP Released	8/11/2021	1/23/2023

Contract Number (s)
H0022 , H6080 , H6870 , H0480 , H1723 , H3237 , H9487

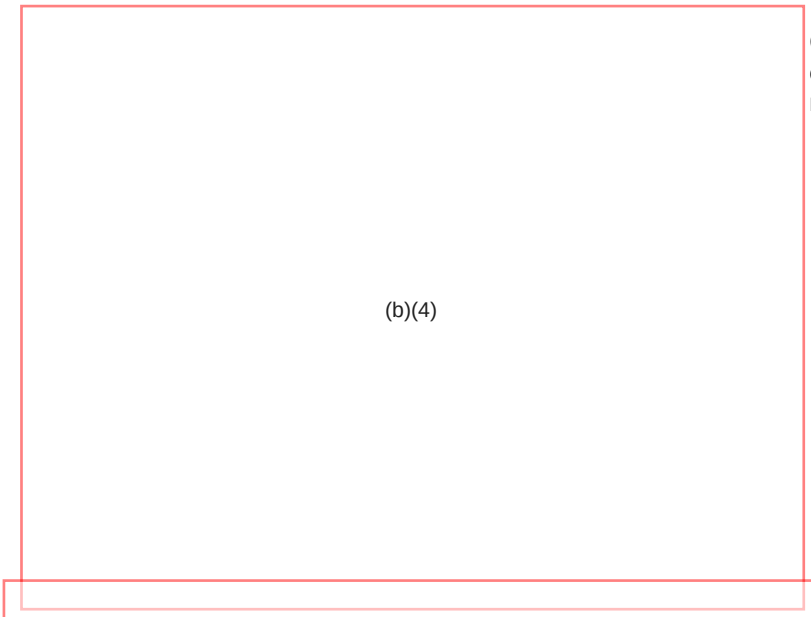
Condition Language
Sponsor did not notify enrollees of its standard service authorization request decisions timely.

Cause
Sponsor's system was not appropriately configured to send approval notifications to enrollees for home and community based services. Additionally, some notifications were untimely due to staff failing to follow established processes for mailing notifications at the conclusion of the Sponsor’s decisions.

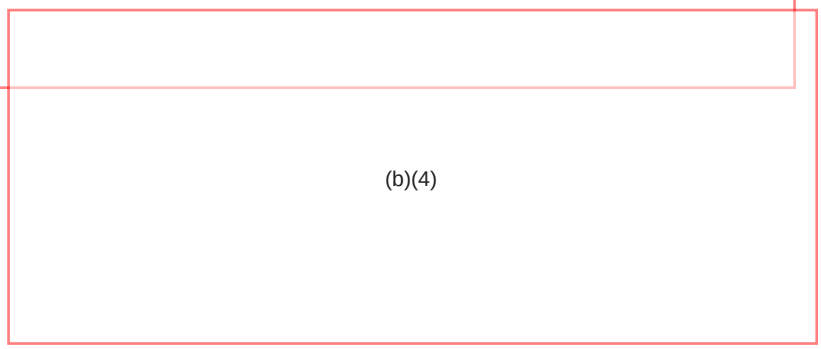
Effect
Of the 2,321 cases evaluated for the Illinois contract, 827 cases were non-compliant for late notification of coverage decisions for MMP standard service authorization requests. Of the 4,788 cases evaluated for the Ohio contract, 246 cases were non-compliant for late notification of coverage decisions for MMP standard service authorization requests. Of the 3,103 cases evaluated for the Texas contract, 74 cases were non-compliant for late notification of coverage decisions for MMP standard service authorization requests. Of the 1,257 cases evaluated for the South Carolina contract, nine cases were non-compliant for late notification of coverage decisions for MMP standard service authorization requests. Of the 3,997 cases evaluated for the Michigan contract, 26 cases were non-compliant for late notification of coverage decisions for MMP standard service authorization requests. Of the 9,354 cases evaluated for the California contract, 17 cases were non-compliant for late notification of coverage decisions for MMP standard service authorization requests. In total, of the 24,820 cases evaluated, 1,199 cases were noncompliant for late notification of standard service authorization requests.

CAP Submission 1

Project Completion Date: 8/31/2021



CAP accepted as it describes the process for implementing correction and corrective actions taken to systemically cure the non-compliance.



CAP Monitoring 1

Project Completion Date: 8/31/2021

Org CAP Submission 1 - 1/23/2023 3:45 PM	CMS CAP Response 1 - 1/23/2023 3:47 PM
No response required.	No response required.

Finding ID: 40390

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
40390	#7.104	Appropriateness of Clinical Decision-Making & Compliance with Processing Requirements	CAR	CAP Released	12/8/2021	1/23/2023

Contract Number (s)
H0022

Condition Language
Sponsor did not notify enrollees in writing of the reason for the delay, and their right to file an expedited grievance, when Sponsor granted itself extensions to processing timeframes for standard or expedited service authorization requests and/or appeals.

Cause
Sponsor lacked a process to ensure staff followed established procedures for including rationale for taking an extension in enrollee notifications.

Effect
Sponsor identified three enrollees that received notifications of an extension to the processing timeframes that did not include the reason for the extension.

CAP Submission 1

Project Completion Date: 2/10/2022

(b)(4)	CAP is acceptable.

CAP Monitoring 1

Project Completion Date: 2/10/2022

Org CAP Submission 1 - 1/23/2023 3:45 PM	CMS CAP Response 1 - 1/23/2023 3:47 PM
No response required.	No response required.

Finding ID: 41675

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
41675		Appropriateness of Clinical Decision-Making & Compliance with Processing Requirements	Observation	CAP Released	12/8/2021	1/23/2023

Observation Language
In one case, Sponsor inappropriately extended the processing timeframe of an expedited service authorization request due to a lack of understanding of the requirements to extend processing timeframes, per the State of Ohio contract. This observation requires correction and submission of a corrective action plan (CDM-31, Centene SARAG CDM Extension Notification IA V2. xlsx).

CAP Submission 1

Project Completion Date: 11/22/2021

	CMS CAP Response 1 - 12/9/2021 11:59 AM
(b)(4)	CAP is acceptable.

CAP Monitoring 1

Project Completion Date: 11/22/2021

Org CAP Submission 1 - 1/23/2023 3:45 PM	CMS CAP Response 1 - 1/23/2023 3:47 PM
No response required.	No response required.

Program Area: Medicare Medicaid Plan - Care Coordination Quality Improvement Program Effectiveness (MMP-CCQIPE)

Finding ID: 40363

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
40363	#8.17	Care Coordination	CAR	CAP Released	12/8/2021	1/23/2023

Contract Number (s)
H6870 , H1723 , H6080

Condition Language
Sponsor did not coordinate Individualized Care Plan (ICP) communications among plan personnel, providers, and enrollees.

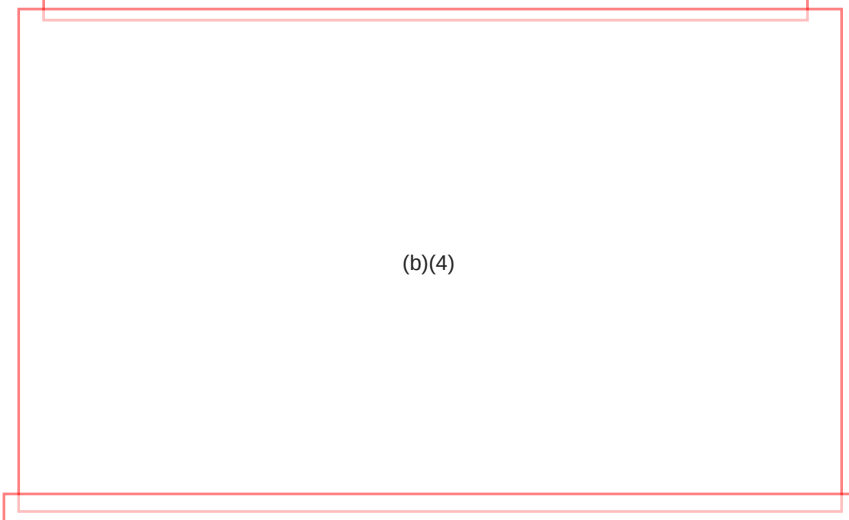
Cause
Sponsor's care managers did not follow established procedures for sharing ICPs with enrollees.

Effect
Sponsor identified 98 enrollees whose ICPs were not shared with the enrollee and/or provider, as required in the States of South Carolina, Illinois, and Texas contracts.

CAP Submission 1

Project Completion Date: 12/31/2021

CAP is acceptable.



(b)(4)

CAP Monitoring 1

Project Completion Date: 12/31/2021

Org CAP Submission 1 - 1/23/2023 3:53 PM	CMS CAP Response 1 - 1/23/2023 3:56 PM
No response required.	No response required.

Finding ID: 40362

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
40362	#8.15	Care Coordination	CAR	CAP Released	12/8/2021	1/23/2023

Contract Number (s)
H6080 , H3237 , H1723 , H9487

Condition Language
Sponsor did not develop, review and/or revise individualized care plans (ICPs) consistent with the contract or as warranted by changes in the health status or care transitions of enrollees.

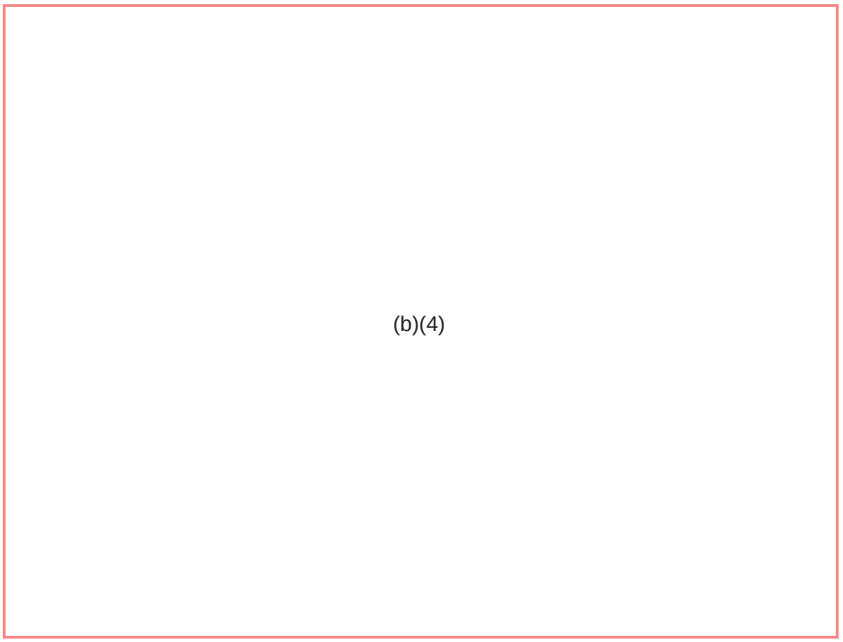
Cause
Four root causes contributed to this condition. First, Sponsor did not schedule contacts with enrollees timely to review and update ICPs due to staffing shortages. Second, Sponsor staff lacked an understanding of how to use internal reports to identify enrollees due for ICP updates. Third, Sponsor staff did not follow established procedures for ensuring ICPs were updated timely. Fourth, Sponsor identified training gaps related to the requirements for using HRA responses as the foundation for developing and revising ICPs.

Effect
This condition affected enrollees in two ways. First, Sponsor identified 238 enrollees that did not have an updated ICP, as required in the States of South Carolina, Illinois, Michigan, and California contracts. Second, Sponsor was unable to identify the number of enrollees whose ICPs did not address issues identified in HRAs.

CAP Submission 1

Project Completion Date: 12/31/2021

Org CAP Submission 1 - 12/2/2021 1:09 PM	CMS CAP Response 1 - 12/9/2021 11:48 AM
(b)(4)	CAP is acceptable.
(b)(4)	
(b)(4)	


(b)(4)

CAP Monitoring 1

Project Completion Date: 12/31/2021

Org CAP Submission 1 - 1/23/2023 3:53 PM	CMS CAP Response 1 - 1/23/2023 3:56 PM
No response required.	No response required.

Finding ID: 40915

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
40915	#8.31	Care Coordination	Observation	CAP Released	12/8/2021	1/23/2023

Observation Language
Sponsor did not conduct initial health risk assessments for 24 enrollees within 60 days of enrollment, as required in the State of Illinois contract. Sponsor identified a gap in its process when enrollees change their status from Community to Long-Term Care Facility within the first 90 days of enrollment. This observation requires correction and submission of a corrective action plan (MMPM-7, Centene_CCQIPE_Untimely IHRA IA_V2.xlsx).

CAP Submission 1

Project Completion Date: 12/31/2021

(b)(4)	CAP is acceptable.

CAP Monitoring 1

Project Completion Date: 12/31/2021

Org CAP Submission 1 - 1/23/2023 3:53 PM	CMS CAP Response 1 - 1/23/2023 3:56 PM
No response required.	No response required.

Finding ID: 40914

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
40914	#8.24	Care Coordination	Observation	CAP Released	12/8/2021	1/23/2023

Observation Language
Sponsor did not implement transition protocols between settings for 34 enrollees through outreach to enrollees and/or primary care providers, in accordance with the State of Illinois and Texas contracts. Sponsor identified a gap in its process for communicating admissions and discharges amongst utilization managers and case management. This observation requires correction and submission of a corrective action plan (MMPM-7, MMPM-14, MMPM-20, Centene_CCQIPE_Transition of Care IA.xlsx).

CAP Submission 1

Project Completion Date: 12/31/2021

Org CAP Submission 1 - 12/2/2021 1:09 PM	CMS CAP Response 1 - 12/9/2021 11:48 AM
(b)(4)	CAP is acceptable.
(b)(4)	

CAP Monitoring 1

Project Completion Date: 12/31/2021

Org CAP Submission 1 - 1/23/2023 3:53 PM	CMS CAP Response 1 - 1/23/2023 3:56 PM
No response required.	No response required.

Finding ID: 40913

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
40913	#2.19	Care Coordination	Observation	CAP Released	12/8/2021	1/23/2023

Observation Language
Sponsor did not conduct interdisciplinary care team (ICT) meetings for 27 enrollees within 12 months of the previous ICT meeting, in accordance with the State of Illinois and South Carolina contracts. Sponsor identified a gap in its process amongst case managers for identifying those enrollees nearing due dates for ICT meetings and ensuring assigned tasks were completed. This observation requires correction and submission of a corrective action plan (MMPM-14, MMPM-23, Centene_CCQIPE_ICT Functions IA_V2.xlsx).

CAP Submission 1

Project Completion Date: 12/31/2021

(b)(4)

(b)(4)

CMS CAP Response 1 - 12/9/2021 11:48 AM

CAP is acceptable.

CAP Monitoring 1

Project Completion Date: 12/31/2021

Org CAP Submission 1 - 1/23/2023 3:53 PM	CMS CAP Response 1 - 1/23/2023 3:56 PM
No response required.	No response required.

Finding ID: 40910

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
40910	#8.08	Care Coordination	Observation	CAP Released	12/8/2021	1/23/2023

Observation Language
Sponsor did not develop ICPs for six enrollees within 90 days of enrollment, as required in the State of South Carolina contract. Sponsor identified a gap in its process amongst case managers for identifying those enrollees nearing due dates for ICP development. This observation requires correction and submission of a corrective action plan (MMPM-21, Centene_CCQIPE_ICP Development IA_V2.xlsx).

CAP Submission 1

Project Completion Date: 10/6/2021

(b)(4)

CAP is acceptable.

(b)(4)

CAP Monitoring 1

Project Completion Date: 10/6/2021

Org CAP Submission 1 - 1/23/2023 3:53 PM	CMS CAP Response 1 - 1/23/2023 3:56 PM
No response required.	No response required.

Finding ID: 40909

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
40909	#8.07	Care Coordination	Observation	CAP Released	12/8/2021	1/23/2023

Observation Language
Sponsor did not conduct reassessments of 21 enrollees timely, in accordance with the States of Illinois and South Carolina contracts. Sponsor identified a gap in its process amongst case managers for identifying those enrollees nearing due dates for reassessments and ensuring assigned tasks were completed. This observation requires correction and submission of a corrective action plan (MMPM-4, MMPM-14, Centene_CCQIPE_Untimely HRA IA.xlsx).

CAP Submission 1

Project Completion Date: 12/31/2021

(b)(4)

AP is acceptable.

(b)(4)

(b)(4)

CAP Monitoring 1

Project Completion Date: 12/31/2021

Org CAP Submission 1 - 1/23/2023 3:53 PM	CMS CAP Response 1 - 1/23/2023 3:56 PM
No response required.	No response required.

Pages 250 through 285 redacted for the following reasons:
- -
(b)(4)

Finding ID: 29009

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
29009	#4.52	Appropriateness of Clinical Decision-Making & Compliance with Processing Requirements	ICAR	CAP Released	7/17/2018	7/17/2018

Contract Number (s)
H3822 , H8554 , H3251 , H3979 , H8133 , H8634 , H0107 , H1666

Condition Language
Sponsor did not render appropriate denials of pre-service organization determinations.

Cause
Two root causes contributed to this condition. First, clinical reviewers applied the incorrect guideline when rendering determinations. Second, clinical reviewers misinterpreted the applicable guideline when rendering determinations.

Effect
Based on Sponsor's impact analysis, a total of 30 enrollees were inappropriately denied medical services. Inappropriate denials cause delays in enrollees' access to needed medical services.

CAP Submission 1

Project Completion Date:

Org CAP Submission 1 - 5/11/2018 4:54 PM	CMS CAP Response 1 - 5/11/2018 5:15 PM
Corrective actions that have been implemented to immediately stop and prevent non-compliance include: • For the files reviewed during the audit, the following actions have been taken: o HCSC's delegate eviCore has implemented updated National Comprehensive Cancer Network (NCCN) guidelines into the current clinical management system so that staff are using the correct guidelines when rendering determinations. o eviCore provided and re-trained all its agents processing Oncology cases to further their understanding of the updated NCCN policy and procedures. o As of May 9, 2018, HCSC has retrained its staff on the appropriate application and interpretation of the criteria in the clinical standard at issue in the case. o HCSC's delegate eviCore provided training to utilization management staff and medical directors to further their understanding on the selection of the proper clinical guidelines and coverage criteria. The training also covered how to apply the criteria in the updated guideline to make clinically appropriate pre-service determinations. o Behavioral Health Medical directors received training May 10, 2018 regarding NCD and LCD criteria application. The following describes how adversely impacted enrollees are being remediated: • All IRE overturned decisions have been effectuated. Additional measures that will be implemented to prevent the non-compliance from recurring include: • To address the other cases impacted and to prevent the issue from recurring, HCSC has enhanced its FDR Oversight Monitoring Work Plan, which was approved 4/23/18. The plan includes, but is not limited to: o Quality team reviews cases in the eviCore portal for UM decision and notification timeliness, correct letter templates, correct use and application of criteria, adequate denial letter language. Findings are discussed. o Medical Management Audit team pulls samples monthly and reports findings for analysis, tracking and trending. o HCSC Medical Director provides monitoring oversight review and provides recommendations to Delegation Oversight Committee. The Medical Director, and Operational and Delegation Oversight teams, work collaboratively with the vendor	Returning to Sponsor at their request so that additional edits can be made

to ensure criteria are applied consistently and remain in alignment with HCSC standards. o Audits will be conducted on a quarterly basis to include: o Random sample of a minimum of 10 cases from each month in the audit quarter o IRE overturned appeals cases that are not based on additional clinical information or change in patient clinical status o Additional reviews may be conducted at Medical Director discretion based on monitoring results, which may include approvals, denials and appeals • HCSC and the associated delegate, eviCore, will complete an end-to-end review of the process for updating relevant clinical criteria and guidelines, including how these guidelines are reviewed and disseminated for use by medical directors or other clinical staff in making organizational determinations. • By the end of May 2018, eviCore will conduct internal audit reports on both the physician who denied CDM-39 and medical oncology requests. 15 monitoring audits will be completed on the physician and 10 audits per week will be completed on the medical oncology requests.	

CAP Submission 2

Project Completion Date:

Org CAP Submission 2 - 5/11/2018 5:30 PM	CMS CAP Response 2 - 7/17/2018 10:32 PM
Corrective actions that have been implemented to immediately stop and prevent non-compliance include: • For the files reviewed during the audit, the following actions have been taken: o HCSC's delegate eviCore has manually implemented updated National Comprehensive Cancer Network (NCCN) guidelines and is working to implement them into the current clinical management system so that staff are using the correct guidelines when rendering determinations. o eviCore provided and re-trained all its agents processing Oncology cases to further their understanding of the updated NCCN policy and procedures. o As of May 9, 2018, HCSC has retrained its staff on the appropriate application and interpretation of the criteria in the clinical standard at issue in the case. o HCSC's delegate eviCore provided training to utilization management staff and medical directors to further their understanding on the selection of the proper clinical guidelines and coverage criteria. The training also covered how to apply the criteria in the updated guideline to make clinically appropriate pre-service determinations. o Behavioral Health Medical directors received training May 10, 2018 regarding NCD and LCD criteria application. The following describes how adversely impacted enrollees are being remediated: • All IRE overturned decisions have been effectuated. Additional measures that will be implemented to prevent the non-compliance from recurring include: • To address the other cases impacted and to prevent the issue from recurring, HCSC has enhanced its FDR Oversight Monitoring Work Plan, which was approved 4/23/18. The plan includes, but is not limited to: o Quality team reviews cases in the eviCore portal for UM decision and notification timeliness, correct letter templates, correct use and application of criteria, adequate denial letter language. Findings are discussed. o Medical Management Audit team pulls samples monthly and reports findings for analysis, tracking and trending. o HCSC Medical Director provides monitoring oversight review and provides recommendations to Delegation Oversight Committee. The Medical Director, and Operational and	System changes have been made to incorporate the correct guidelines and additional training has been conducted. Since these determinations are handled by HCSC's delegate, EviCore, additional FDR oversight efforts were implemented, including quality review, reporting, and Medical Director oversight. CAP is accepted, as it should remediate the finding as it reads, if implemented effectively.

Delegation Oversight teams, work collaboratively with the vendor to ensure criteria are applied consistently and remain in alignment with HCSC standards.

o Audits will be conducted on a quarterly basis to include:

o Random sample of a minimum of 10 cases from each month in the audit quarter

o IRE overturned appeals cases that are not based on additional clinical information or change in patient clinical status

o Additional reviews may be conducted at Medical Director discretion based on monitoring results, which may include approvals, denials and appeals

• HCSC and the associated delegate, eviCore, will complete an end-to-end review of the process for updating relevant clinical criteria and guidelines, including how these guidelines are reviewed and disseminated for use by medical directors or other clinical staff in making organizational determinations.

• By the end of May 2018, eviCore will conduct internal audit reports on both the physician who denied CDM-39 and medical oncology requests. 15 monitoring audits will be completed on the physician and 10 audits per week will be completed on the medical oncology requests.

CAP Monitoring 1

Project Completion Date:

Org CAP Submission 1 - 5/13/2020 2:41 PM	CMS CAP Response 1 - 5/13/2020 2:42 PM
No response required	No response required

Pages 292 through 351 redacted for the following reasons:
- -
(b)(4)

Finding ID: 29002

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
29002	#7.44	Timeliness	CAR	CAP Released	10/23/2018	10/23/2018

Contract Number (s)
H0927

Condition Language
Sponsor did not effectuate its determinations within 72 hours of receipt of expedited appeal requests.

Cause
Three root causes contributed to this condition. First, Sponsor lacked adequate resources dedicated to appeals and grievances processing resulting in a significant and ongoing backlog of open and aged appeals. Second, Sponsor lacked a fully implemented process that defined roles and responsibilities and end-to-end management oversight over the appeals and grievances processes. Third, Sponsor's processes did not include appropriate monitoring to ensure approved appeals were effectuated when received from its delegated entity.

Effect
Of the 15 cases evaluated from the MMP Expedited Plan Level Appeals (MEPLA) universe, three cases were non-compliant for untimely effectuation of approved MMP expedited plan level appeals. Also, an unknown number of additional enrollees affected by the backlog of open and aged appeals were impacted by this condition. Late effectuation causes delays in members' access to needed medical services.

CAP Submission 1

Project Completion Date:

Org CAP Submission 1 - 9/13/2018 4:27 PM	CMS CAP Response 1 - 10/31/2018 8:36 AM
We have implemented corrective actions to prevent non-compliance and have additional measures planned for implementation in order to strengthen controls to prevent future occurrences of non-compliance. Refined Staffing Model and Forecasting Processes • On 04/02/2018, HCSC created a dedicated Medicare/MMAI Expedited Appeals team. The Expedited Appeals team work schedule provides coverage each day, including Saturday and Sunday. • On 04/02/2018, HCSC created a system enhancement to facilitate prioritization of work for the Expedited Appeals team. This includes a series of filters in the “Get Work” inventory management system. The enhancement enables tracking the progress of all open expedited appeals so that the supervisor can prioritize work assignments. Appeal Specialists hold a “view only” access in “Get Work” to ensure that the data cannot be improperly manipulated. On 05/08/2018, HCSC began to use this system enhancement. At the end of each business day, the Appeals Specialist Supervisor exports a “Get Work” open expedited appeals report, which is used to track the open expedited appeals requiring closure the next business day. • On April 16, 2018, HCSC added dedicated specialists charged with monitoring the receipt of all expedited reconsideration determinations and the associated due dates for effectuation of decisions. HCSC plans to continue to add dedicated specialists as necessary. • Divisional Vice Presidents have been hired, dedicated to Medicare Appeals and MMAI Appeals & Grievances, to improve management oversight of the end-to-end process. • Beginning in October 2018, a monthly leadership meeting will be established to review underlying metrics such as trends in receipts, productivity levels and potential environmental conditions that could impact the future volumes of grievances. Clarified Staff Responsibilities & Expectations • As of 4/17/2018, HCSC reviewed and updated the effectuation process for expedited appeals to ensure clarity for timeliness of the effectuation of determinations received from Evicore. • On 5/02/2018, the Expedited Appeals team was trained by the Appeals Specialist Supervisor on the “Expedited Appeals/Reconsideration Check-List,” a technical job aid.	CMS accepts Sponsor's CAP submission.

• On 5/31/2018, HCSC completed its development and/or amendment of its policies, procedures, and job aids for the Appeals Supervisory monitoring functions, the Expedited Appeals team and the Mail Box teams to further formalize the process. • On 5/31/2018, HCSC established a routine meeting with eviCore to explore opportunities to enhance and streamline the expedited appeals process. Developed Actionable Reporting • Dedicated inventory management staff generate and monitor a daily inventory report to ensure timely and complete processing of expedited appeals, including notification of determinations. This report is used to drive daily priorities and identify potential escalations. • A daily dashboard is published to provide a snapshot of current inventory to MMAI leadership. • A weekly report is published to Operational and Compliance leadership that highlights key performance metrics and emerging trends.	

CAP Monitoring 1

Project Completion Date:

Org CAP Submission 1 - 5/13/2020 3:09 PM	CMS CAP Response 1 - 5/13/2020 3:10 PM
No response required	No response required

Pages 356 through 359 redacted for the following reasons:
- -
(b)(4)

Finding ID: 29001

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
29001	#7.05	Timeliness	ICAR	CAP Released	7/20/2018	7/20/2018

Contract Number (s)
H0927

Condition Language
Sponsor did not notify enrollees, and providers when appropriate, of its determinations within 72 hours of receipt of expedited appeals requests.

Cause
Three root causes contributed to this condition. First, Sponsor lacked adequate resources dedicated to appeals and grievances processing resulting in a significant and ongoing backlog of open and aged appeals. Second, Sponsor lacked a fully implemented process that defined roles and responsibilities and end-to-end management oversight over the appeals and grievances processes. Third, Sponsor's processes did not include appropriate monitoring to ensure members were notified of determinations when received from its delegated entity.

Effect
Of the 21 cases evaluated from the MEPLA universe, 18 cases were non-compliant for untimely notification of coverage decisions for MMP expedited plan level appeals. Also, an unknown number of additional enrollees affected by the backlog of open and aged appeals were impacted by this condition. Late notification causes delays in members' access to needed medical services.

CAP Submission 1

Project Completion Date:

Org CAP Submission 1 - 5/11/2018 4:55 PM	CMS CAP Response 1 - 7/18/2018 7:01 AM
Corrective actions that have been implemented to immediately stop and prevent non-compliance include: • On 04/02/2018, HCSC has created a dedicated Medicare Expedited Appeals team of four Appeals Specialists and two Nurses who are responsible for processing expedited appeals. The Expedited Appeals team work schedule provides coverage each day, including Saturday and Sunday. • On 04/02/2018, HCSC created a system enhancement to facilitate prioritization of work for the Expedited Appeals team. This includes a series of filters in the “Get Work” inventory management system. The enhancement enables tracking the progress of all open expedited appeals so that the supervisor can prioritize work assignments. Appeal Specialists hold a “view only” access in “Get Work” to ensure that the data cannot be improperly manipulated. On 05/08/2018, HCSC began to use this system enhancement. At the end of each business day, the Appeals Specialist Supervisor exports a “Get Work” open expedited appeals report, which is used to track the open expedited appeals requiring closure the next business day. • HCSC established a dedicated “Mail Box” team of three employees who are responsible for triaging all appeal determinations received by email. The team identifies expedited appeals and prioritizes them. • On 4/24/2018, the Appeals Specialist Supervisor reinforced with the Mail Box team the importance of adhering to the turnaround time standards set forth by CMS for expedited appeals. • On 5/02/2018, the Expedited Appeals team was trained by the Appeals Specialist Supervisor on the “Expedited Appeals/Reconsideration Check-List,” a technical job aid. • Because the Mail Box team is new, Appeals Specialist Supervisor is conducting a 100% quality check of their work to ensure that they are completely and accurately categorizing and prioritizing incoming appeal cases. As the team matures, the quality review process will be a sampling. The following describes how adversely impacted enrollees are being remediated: • All impacted enrollees’ appeals have been adjudicated in accordance with their benefit plans. • All late appeals and adverse decisions have been sent to the IRE. Additional measures that will be implemented to prevent the non-compliance from recurring include: • By 5/31/2018, HCSC will have completed its development	CMS is requesting resubmission of this CAP for the following reason. There does not appear to be any action taken or planned in the CAP that explains the processes surrounding notification. The processing of the cases has been addressed but there should at least be a statement that indicates if the existing policy addresses notification requirements or even the timeframe in which cases should be processed. Please resubmit revised CAP by COB July 20, 2018.

and/or amendment of its policies, procedures, and job aids for the Appeals Supervisory monitoring functions, the Expedited Appeals team and the Mail Box teams to further formalize the process. • By 5/31/2018, HCSC will have established a routine meeting with eviCore to explore opportunities to enhance and streamline the expedited appeals process.	

CAP Submission 2

Project Completion Date:

Org CAP Submission 2 - 7/20/2018 1:03 PM	CMS CAP Response 2 - 7/20/2018 2:08 PM
Corrective actions that have been implemented to immediately stop and prevent non-compliance include: • On 04/02/2018, HCSC has created a dedicated Medicare Expedited Appeals team of four Appeals Specialists and two Nurses who are responsible for processing expedited appeals. The Expedited Appeals team work schedule provides coverage each day, including Saturday and Sunday. • On 04/02/2018, HCSC created a system enhancement to facilitate prioritization of work for the Expedited Appeals team. This includes a series of filters in the “Get Work” inventory management system. The enhancement enables tracking the progress of all open expedited appeals so that the supervisor can prioritize work assignments. Appeal Specialists hold a “view only” access in “Get Work” to ensure that the data cannot be improperly manipulated. On 05/08/2018, HCSC began to use this system enhancement. At the end of each business day, the Appeals Specialist Supervisor exports a “Get Work” open expedited appeals report, which is used to track the open expedited appeals requiring closure the next business day. • HCSC established a dedicated “Mail Box” team of three employees who are responsible for triaging all appeal determinations received by email. The team identifies expedited appeals and prioritizes them. • On 4/24/2018, the Appeals Specialist Supervisor reinforced with the Mail Box team the importance of adhering to the turnaround time standards set forth by CMS for expedited appeals. • On 5/02/2018, the Expedited Appeals team was trained by the Appeals Specialist Supervisor on the “Expedited Appeals/Reconsideration Check-List,” a technical job aid. • Because the Mail Box team is new, Appeals Specialist Supervisor is conducting a 100% quality check of their work to ensure that they are completely and accurately categorizing and prioritizing incoming appeal cases. As the team matures, the quality review process will be a sampling. The following describes how adversely impacted enrollees are being remediated: • All impacted enrollees’ appeals have been adjudicated in accordance with their benefit plans. • All late appeals and adverse decisions have been sent to the IRE. Additional measures that will be implemented to prevent the non-compliance from recurring include: • By 5/31/2018, HCSC completed its development and/or	CMS is requesting resubmission of this CAP for the following reason. There does not appear to be any action taken or planned in the CAP that explains the processes surrounding notification. The processing of the cases has been addressed but there should at least be a statement that indicates if the existing policy addresses notification requirements or even the timeframe in which cases should be processed. Please resubmit revised CAP by COB July 20, 2018.

amendment of its policies, procedures, and job aids for the Appeals Supervisory monitoring functions, the Expedited Appeals team and the Mail Box teams to further formalize the process. o The policies, procedures and job aid cover all aspects of the processing of expedited appeals, including the following specific to notification: ¿ The enrollee (and the physician involved, as appropriate) will be orally notified of the determination within 72 hours from the receipt to the appeal by HCSC. ¿ The appeals specialist will document in the Enterprise Appeals Application (EAA), the name of the individual(s) orally notified and any call notes, as well as all attempts to reach the individual(s). EAA will systematically time stamp the activity. ¿ The appeals specialist will complete a decision letter, consistent with the oral notification and mail to the appropriate parties within three (3) calendar days of oral notice.	

CAP Monitoring 1

Project Completion Date:

Org CAP Submission 1 - 5/13/2020 3:10 PM	CMS CAP Response 1 - 5/13/2020 3:11 PM
No response required	No response required

Program Area: Medicare Medicaid Plan - Care Coordination Quality Improvement Program Effectiveness (MMP-CCQIPE)

Finding ID: 29014

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
29014	#8.24	Care Coordination	CAR	CAP Released	10/23/2018	10/23/2018

Contract Number (s)
H0927

Condition Language
Sponsor did not implement transition protocols between settings and/or for newly enrolled enrollees to ensure that the delivery of care to the enrollee remains stable.

Cause
Two root causes contributed to this condition. First, Sponsor’s process to notify its care coordinators of member hospitalizations was inconsistent. Second, when care coordinators were aware of hospitalization, Sponsor's care protocols were not implemented in accordance with its process.

Effect
A total of 801 members did not receive care transition coordination, as required by the contract. Failure to implement transition of care protocols inhibits Sponsor's ability to identify member needs and maintain continuity of care.

CAP Submission 1

Project Completion Date:

Org CAP Submission 1 - 9/13/2018 4:28 PM	CMS CAP Response 1 - 10/31/2018 8:37 AM
Corrective actions that have been implemented to immediately stop and prevent non-compliance include: • Policies and Procedures (P&Ps) have been revised to implement transition protocols and coordinate care for new members and for members during and/or after a transition event to ensure that the delivery of care to the enrollee remains stable. P&Ps are scheduled to be approved 9/14/18. The P&Ps describe the process of a transition event, consistent with Medicare-Medicaid Alignment Initiative contract (IL), Sections 2.5.2.1 and 2.6.10 • HCSC's Care Coordination Clinic is a monthly training forum in which management delivers key procedural updates. On 6/12/18 and 6/26/18, staff received refresher training regarding TOC requirements contained in IL MMAI contract, Sections 2.5.2.1 and 2.6.10. Training provided guidance to ensure implementation of transition protocols between settings and for newly enrolled enrollees to ensure that the delivery of care to the enrollee remains stable. TOC training was recorded, will be converted to a Computer Based Training (CBT), and will be available in the Learning & Development (L&D) system for future training. In addition, the July clinic included training on TOC protocols. • HCSC has a dedicated TOC team responsible for hospital to home transitions. UM census reports of member activity are forwarded daily to TOC management for assignment of TOC activities. For transition/continuity of care for new enrollees, enrollees transitioning to or from facilities or the community, HCSC ensures members are supported by the assigned Care Coordinators. • In September 2018 the TOC team implemented changes in their processes to improve Transition of Care. These improvements include 1) An escalation process for non-compliant or difficult to engage facilities or providers. 2) An improved Utilization Management (UM) workflow to ensure communication to TOC team. 3) Development of job aids to assist in utilizing appropriate transition protocols for members transitioning to or from the community, acute, LTAC, rehab or SNF levels of care. 4) Improved communication process between behavioral health and physical health TOC and CC teams. The following described how adversely impacted enrollees are being remediated:	CMS accepts Sponsor's CAP submission.

• On 7/13/2018, BCBSIL coordination staff completed initial telephonic outreach to the 801 impacted members to offer care coordination and ensure TOC needs were met. • The clinical regulatory team began validation of CC completion for all 801 impacted members. Validation will be complete by 9/28/2018 Additional measures that will be implemented to prevent the non-compliance from recurring include: • Review reports of tasks between UM and CC and supplement with reviews of case notes as evidence of communication between operational areas to ensure CCs are providing continuity of care for all enrollees and coordinating with members of the ICT. • A dashboard is in development that will enable TOC managers to provide oversight over TOC activities. The dashboard will be completed by 12/31/2018. • TOC managers will review the dashboard weekly for compliance with TOC activities. • HCSC will complete implementation of enhancements to its dedicated MMAI team by 11/1/2018. • The Clinical Oversight Team in May 2018 revised the process of conducting monthly audits of CC TOC activities through use of the NICE Interaction Management system. Audits are now chosen randomly from a universe to capture care transitions. NICE allows the Clinical Oversight team to capture interactions between the CC staff and the members to improve quality and ensure compliance. CCs receive staff coaching and performance monitoring based on performance results. • Beginning in June 2018, the Clinical Oversight Team has been performing monthly Mock Audits of MMAI and CMS requirements by reviewing member records to verify all TOC opportunities have been identified and managed by the care coordinator.	

CAP Monitoring 1

Project Completion Date:

Org CAP Submission 1 - 5/13/2020 3:17 PM	CMS CAP Response 1 - 5/13/2020 3:19 PM
No response required	No response required

Finding ID: 29013

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
29013	#8.15	Care Coordination	CAR	CAP Released	10/23/2018	10/23/2018

Contract Number (s)
H0927

Condition Language
Sponsor did not review and/or revise individualized care plans (ICPs) consistent with the contract or as warranted by changes in the health status or care transitions of members.

Cause
Sponsor's process to manually enter tasks into the care coordination system was not effective in ensuring that ICPs were reviewed and revised in accordance with contract requirements.

Effect
A total of 2,286 members had ICPs that were not reviewed and revised, in accordance with contract requirements. This resulted in members being denied the benefit of an ICP that addressed the most current needs.

CAP Submission 1

Project Completion Date:

Org CAP Submission 1 - 9/13/2018 4:28 PM	CMS CAP Response 1 - 10/31/2018 8:37 AM
Corrective actions that have been implemented to immediately stop and prevent non-compliance include: • HCSC's Care Coordination Clinic is an ongoing monthly training forum in which management delivers key procedural updates and reviews. On 6/12/18 and 6/26/18, staff were provided with refresher training regarding ICP reviews and/or revisions consistent with contractual requirements including when warranted by changes in the health status or care transitions of members (Medicare-Medicaid Alignment Initiative (MMAI) contract (IL), Section 2.6.4). • The care management platform, Guiding Care, as of 9/4/2018 has been configured to align with contractual definitions of care transitions and automatically trigger an activity/task for follow up and care plan update based on member's program type and changes in stratification. The activity is assigned to the member record compared to our previous process in which activities were established and assigned to the Care Coordinator (CC). • Care Coordinators perform 90-day case reviews to identify changes in the health status or care transitions of members using indicators including, but not limited to, severity level, review for authorizations, and HRA health conditions to ensure ICP reviews and/or revisions are completed. The following described how adversely impacted enrollees are being remediated: • As of 8/31/18, BCBSIL coordination staff completed telephonic or face-to-face outreach to review and revise ICPs for the 2,286 impacted members identified during the CMS audit. • Cases were reassigned to CCs to conduct outreach to impacted members. The "Feet on the Street" team and Community Health Workers also assisted in contacting the impacted members. In addition, newly hired staff were assigned members for outreach to ensure all members were outreached. • Upon completion, the Clinical Regulatory Team began validation of the completion of outreach and ICP reviews and revisions. Validation will be completed by 9/28/18. Additional measures that will be implemented to prevent the non-compliance from recurring include: • The care plan completion report from Guiding Care is being developed to provide operational reporting utilizing the new definitions added to the system for care plan review alerts. The report will identify members lacking required ICP reviews and	CMS accepts Sponsor's CAP submission.

revisions as defined in the MMAI contract and CMS protocols. The report will be in production by 10/31/18. • Unit managers will monitor the care plan report on a monthly basis for overdue or near due care plans. • HCSC will complete implementation of enhancements to its dedicated MMAI team by 11/1/2018. • Beginning in May 2018, the Clinical Oversight Team revised the process of conducting monthly audits of CC ICP activities through use of the NICE Interaction Management system. Audits are now chosen randomly from a universe to capture care plan revisions. NICE identifies a series of questions and allows the Clinical Oversight team to capture interactions between the care coordination staff and the members to improve quality management and ensure regulatory compliance. • HCSC has developed a regulatory oversight team that will continuously review contractual requirements on a monthly basis. In May 2018 this team began conducting monthly monitoring meetings in which contractual and regulatory protocols are reviewed. Failure points will be discussed and analyzed for correction. Issues will be escalated for visibility and resolution by Leadership and the Quality Assurance Committee (QAC). • Beginning in June 2018, the Clinical Oversight Team performed monthly Mock Audits of MMAI and CMS requirements by reviewing Member records to verify ICPs have been reviewed and revised according to the contract or as warranted by a change in the Member's condition.	

CAP Monitoring 1

Project Completion Date:

Org CAP Submission 1 - 5/13/2020 3:19 PM	CMS CAP Response 1 - 5/13/2020 3:20 PM
No response required	No response required

Finding ID: 29012

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
29012	#8.08	Care Coordination	CAR	CAP Released	10/23/2018	10/23/2018

Contract Number (s)
H0927

Condition Language
Sponsor did not develop Individualized Care Plans (ICP) for enrollees.

Cause
Sponsor's process to manually enter tasks into the care coordination system was not effective in ensuring that ICPs were assigned and completed.

Effect
A total of 1,272 members did not have an ICP which results in inadequate or inconsistent continuity of care.

CAP Submission 1

Project Completion Date:

Org CAP Submission 1 - 9/13/2018 4:28 PM	CMS CAP Response 1 - 10/31/2018 8:37 AM
Corrective actions that have been implemented to immediately stop and prevent non-compliance include: • On 9/4/2018, a rule in Guiding Care (the care management system) was defined to alert Care Coordinators (CCs) to trigger activities for care plan completion prior to 90 days post enrollment. The Guiding Care system rule is used to prevent the manual tasking process and ensure that Individualized Care Plans (ICPs) are assigned and completed, consistent with Medicare-Medicaid Alignment Initiative (MMAI) contract (IL), Section 2.6.4. • MMAI Policies and Procedures (P&Ps) specific to care plans have been reviewed and revised to effectively maintain a comprehensive ICP for each enrollee. The revised P&Ps describe the process to enter tasks into the care coordination system to ensure that ICPs are assigned and completed, consistent with MMAI contract (IL), Section 2.6.4. • HCSC's Care Coordination Clinic is an ongoing monthly training forum in which management delivers key procedural updates. On 6/12/18 and 6/26/18, staff were provided with refresher training, which provided guidance to correctly complete system transactions to effectively complete a care plan for enrollees. Attendance was captured, and the training was recorded via WebEx. The following described how adversely impacted enrollees are being remediated: • 1,272 members did not have an ICP completed timely. 309 members out of the 1,272 members did not have an ICP at all. The 309 members assessed without a completed ICP were identified and assigned to CCs. CCs completed all required ICP reviews and updates as of 7/15/18. Upon completion by the CCs, the clinical regulatory team began validating that Individualized Care Plans (ICP) have been developed for all members. Validation will be completed by 9/28/18. Additional measures that will be implemented to prevent the non-compliance from recurring include: • The care plan completion report from Guiding Care is being developed to provide operational reporting utilizing the new definitions added to the system for care plan review alerts. The report, scheduled to be in production by 10/31/18, will identify members without an ICP developed. • Initial ICP development can be identified when unit managers review monthly ICP report. Unit managers will monitor monthly reports of the care management system for alerts/notifications of	CMS accepts Sponsor's CAP submission.

any upcoming and overdue care plan activities. • HCSC will complete implementation of enhancements to its dedicated MMAI team by 11/1/2018. • The Clinical Oversight Team in May 2018 revised the process of conducting monthly audits of ICP activities through use of the NICE Interaction Management system. Beginning in May 2018, Audits were chosen randomly from a universe to capture ICP development. NICE allows the Clinical Oversight team to capture interactions between the care coordination staff and the members to improve quality management and ensure regulatory compliance. • HCSC has developed a regulatory oversight team that will continuously review contractual requirements on a monthly basis. In May 2018 this team began conducting monthly monitoring meetings in which contractual and regulatory protocols are reviewed. Failure points are discussed and analyzed for correction. Issues are escalated for visibility and resolution by Leadership and the Quality Assurance Committee (QAC). • In June 2018, the Clinical Oversight Team began performing monthly Mock Audits of MMAI and CMS requirements by reviewing Member records to verify timely completion of the ICP.	

CAP Monitoring 1

Project Completion Date:

Org CAP Submission 1 - 5/13/2020 3:21 PM	CMS CAP Response 1 - 5/13/2020 3:22 PM
No response required	No response required

Finding ID: 29011

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
29011	#8.07	Care Coordination	CAR	CAP Released	10/23/2018	10/23/2018

Contract Number (s)
H0927

Condition Language
Sponsor did not conduct comprehensive annual reassessments of enrollees within 1 year of initial assessment or within 1 year of previous Health Risk Assessment (HRA), or as often as the health of the enrollees requires.

Cause
Sponsor's process to manually enter tasks into the care coordination system was not effective in ensuring annual reassessments were conducted timely.

Effect
A total of 2,292 members were not administered comprehensive annual HRAs timely. This resulted in an increased risk of enrollees receiving inadequate or inconsistent care for their conditions.

CAP Submission 1

Project Completion Date:

Org CAP Submission 1 - 9/13/2018 4:28 PM	CMS CAP Response 1 - 10/31/2018 8:37 AM
Corrective actions that have been implemented to immediately stop and prevent non-compliance include: • A rule was defined in the Guiding Care case management system on 9/4/2018 to trigger outreach by the Care Coordinator (CC) 275 days post HRA completion with the activity tagged to the member record. The Guiding Care system rule is used to prevent the manual tasking process and ensure that reassessments are conducted timely, consistent with Medicare-Medicaid Alignment Initiative (MMAI) contract (IL), Section 2.6.5. • Reviewed and revised policies and procedures (P&Ps) to conduct comprehensive annual reassessments of enrollees within one year of initial assessment or within one year of previous HRA, or as often as the health of the enrollees requires. The revised P&Ps reflect the enhanced auto-trigger activity within Guiding Care and attempts to complete the annual reassessment prior to the due date. • HCSC's Care Coordination Clinic is an ongoing monthly training forum in which Care Coordination management delivers key procedural updates and reviews. On 6/12/18 and 6/26/18, staff received refresher training on the correct system transactions to successfully and timely complete an assessment and were educated on the requirements contained in MMAI contract (IL), Section 2.6.5. Training provided guidance to conduct comprehensive annual reassessments of enrollees. The following described how adversely impacted enrollees are being remediated: • On 8/31/2018 Care Coordinators (CCs) completed outreach to the 2,292 affected members identified during the CMS audit who had reassessments due. 457 (20%) of these members had completed reassessments, however, the reassessments had been completed outside of the required timeframe. Upon completion of the CC outreach, the clinical regulatory team began validating timely completion of comprehensive annual HRAs for the 2,292 affected members. Validation will be completed by 9/28/18. Additional measures that will be implemented to prevent the non-compliance from recurring include: • A report has been created that includes Members with HRAs coming due or overdue. • Unit Managers will monitor the HRA reports to ensure the Care Coordinators are completing initial HRAs within 90 days of enrollment and annual HRAs within 365 days of the previous	CMS accepts Sponsor's CAP submission.

assessment. • HCSC will complete implementation of enhancements to its dedicated MMAI team by 11/1/2018. • The Clinical Oversight Team in May 2018 revised the process of conducting monthly audits of CC HRA and reassessment activities and performance through use of the NICE Interaction Management system. Audits are now chosen randomly from a universe to capture initial enrollment or annual HRAs. NICE allows the Clinical Oversight team to capture interactions between the care coordination staff and the members to improve quality management and ensure regulatory compliance. Reporting through the NICE system allows Unit Managers to monitor corrections for continued compliance with MMAI contract (IL), Section 2.6.5. • HCSC has developed a regulatory oversight team comprised of regulatory staff that will continuously review contractual requirements on a monthly basis. Since May 2018, this team has conducted monthly monitoring meetings in which contractual and regulatory protocols are reviewed. Failure points are discussed and analyzed for correction. Issues are escalated for visibility and resolution by Leadership and Quality Assurance Committee (QAC). • Beginning in June 2018, the Clinical Oversight Team performed monthly Mock Audits of MMAI and CMS requirements reviewing Member records to verify timely completion of annual HRA.	

CAP Monitoring 1

Project Completion Date:

Org CAP Submission 1 - 5/13/2020 3:22 PM	CMS CAP Response 1 - 5/13/2020 3:23 PM
No response required	No response required

See Conditions
4.39, 7.98, 7.05.

Corrective Action Plan (CAP) Detail Report

CAP Report Search Parameters: **Program Area** = All **Finding Type** = All **CAP Phase** = All **Finding ID** = All **Element** = All

Audit ID	Parent Organization	Exit Conference Date	Entire CAP Accept Date	Entire CAP Release Date
7226	Health Care Service Corporation	5/24/2019	9/24/2019	

Program Area: Part C Organization Determinations, Appeals, and Grievances (ODAG)

Finding ID: 35244

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
35244	#4.39	Appropriateness of Clinical Decision-Making & Compliance with Processing Requirements	CAR	Pending ORG Monitoring	9/13/2019	

Contract Number (s)
H0107 , H3251 , H3822 , H3979 , H1666 , H8133 , H8554 , H8634

Condition Language
Sponsor did not provide denial notices that used the approved notice language in a readable and understandable form including specific reasons for the denial and information regarding the enrollee's right to a reconsideration.

Cause
Sponsor’s delegated entity provided inadequate clinical information in its denial letters for initial requests that did not fully address the necessary criteria on which Sponsor based its clinical decision at the appeal level.

Effect
A total of six enrollees and providers did not receive complete or accurate information in the denial notices. Inadequate denial notices impair the enrollees' and providers’ ability to file an adequate appeal.

CAP Submission 1

Project Completion Date: 10/1/2019

Org CAP Submission 1 - 9/11/2019 1:34 PM	CMS CAP Response 1 - 9/24/2019 2:13 PM
No. 4.39 To address the issue of failing to include consistent medical criteria within the denial rationale of the Initial Denial Notices created by our delegate, eviCore, and the subsequent Notice of Appeal Status letters created internally, the following actions were taken: • The Medical Operations team was notified of the discrepancy between the denial rationale included in the Integrated Denial Notice and subsequent Notice of Appeal Status. In their review of the appeal decision, HCSC's Medical Directors will review the denial rationale included on the IDN to help ensure consistency in member messaging. Discrepancies will be brought to the attention of the Medical Director responsible for the initial denial and coaching will be provided. • By October 1, 2019, the MAPD Appeals department will cease use of the Notice of Appeal Status for denied cases. The Notice of Appeal Status will continue to be used for partial and full approvals. To ensure that the issue does not reoccur, the following monitoring is in place: • Every two weeks, HCSC randomly audits 8-15 cases processed by its delegated entity responsible for the denial rationale identified in the finding. HCSC Medical Operations reviews the results of these audits and discusses any findings with the Medical Directors at the delegated entity. The audit encompasses a review of clinical decision rationales, the criteria utilized, and the notification sent to the member. Specifically, HCSC ensures that the denial decision rationale included in the initial denial lists all the criteria necessary to approve the request upon appeal. • Quarterly, HCSC conducts mock audits of its CMS Program Audit ODAG Universes with each of its delegated entities and internal departments responsible for generating universes. Audits include a review of all member notifications to ensure appropriateness. For denied appeals, denial rationales are compared to rationales included in the Initial Denial Notice to ensure that all criteria reference in the appeal decision were included in the Initial Denial Notice.	CMS accepts this CAP.

Pages 384 through 394 redacted for the following reasons:
- -
(b)(4)

Finding ID: 35267

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
35267	#7.98	Timeliness	ICAR	Pending ORG Monitoring	6/21/2019	

Contract Number (s)
H0927

Condition Language
Sponsor did not notify enrollees or providers of its standard appeals decisions timely.

Cause
Three root causes contributed to this condition. First, in eight cases, Sponsor did not account for the delay caused by delegating the printing and mailing of letters to third party mail vendor and as a result cases processed timely were not placed in the mail stream timely. Second, 16 cases were untimely due to Sponsor's appeals specialists failing to adhere to documented policies and procedures. Third, three cases were untimely because Sponsor's customer service staff routed cases late to the mail vendor.

Effect
Of the 61 cases evaluated, 27 cases were non-compliant for late notification of standard plan level appeal decisions. Late notification causes delays in enrollees' access to needed medical services and further appeals.

CAP Submission 1

Project Completion Date:

Org CAP Submission 1 - 6/20/2019 1:03 PM	CMS CAP Response 1 - 6/26/2019 12:32 PM
Corrective actions that have been implemented to immediately stop and prevent non-compliance include: 1. On April 1, 2019, we implemented the mailroom policy for MMAI appeals. Our process now accounts for the time required to send the case to our mail vendor and enter the mail stream. All reporting is based off of the date the case enters the mail stream. 2. On January 18, 2019, the Appeals Specialist responsible for the late appeals was put on performance action. She received re-training and individual monitoring of her assigned cases. As of April 5, 2019, that Appeals Specialist no longer works on the MMAI Appeals team. 3. On March 26, 2019, we initiated a weekly call with TMG/Cognizant MMAI Operations. The purpose of the call is to disclose and remedy any barriers identified and includes a review of any appeals that may have been misrouted or sent over late by Customer Service. 4. Starting January 1, 2019, eviCore sends a daily report of MMAI cases that have been sent to HCSC. The Coordinator reconciles those cases to inventory in the Enterprise Appeals Application (EAA), HCSC's Appeals system of record, to ensure that all cases sent by eviCore have been received and entered. This check ensures that all cases initially received by eviCore are accounted for within EAA. 5. On June 3, 2019, we hired a Coordinator to focus on MMAI Standard Appeals. The coordinator has been trained in all MMAI appeals policies and workflows, and worked previously on the Expedited Appeals and Grievances team. Job responsibilities include daily oversight and tracking of all MMAI Standard Appeal cases, ensuring timeliness of notification and effectuation, timely communication to delegates, root cause analysis for non-compliant cases, and remediation of errors. 6. On June 14, 2019, we created an MMAI Standard Appeals Tracker. The purpose of the tracker is to track all compliance elements of MMAI Standard Appeals. Appeals are tracked in real time, throughout the lifecycle of the case. 7. Timeliness Tracking Activities: a. Daily: Twice daily, an operations inventory report is sent to all management. All cases are listed by due date and time. Cases are tracked and watched to ensure that they do not age past regulatory timeframes. b. Weekly: On a weekly basis, overall turnaround time is reported to Executive Leadership. Trends, barriers, and actions for improvement are noted.	CMS has reviewed and accepted this CAP.

8. All members of the MMAI Appeals team will receive re-training on the notification process to ensure compliance with all Policies & Procedures and related regulatory requirements by the end of July, 2019. Education materials developed will be incorporated into all future new hire training. Compliance with notification requirements is part of the individual staff quality audit process. Staff identified as non-compliant with the requirements will receive additional training and where necessary, performance action may be taken. The following describes how adversely impacted enrollees are being remediated: 1. No further remediation was required. For the twenty-seven cases identified, we validated that all impacted members received the appropriate notification of authorization or access to further appeal rights.	

Pages 398 through 405 redacted for the following reasons:
- -
(b)(4)

Finding ID: 35270

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
35270	#7.05	Timeliness	CAR	Pending ORG Monitoring	9/13/2019	

Contract Number (s)
H0927

Condition Language
Sponsor did not notify enrollees, and providers when appropriate, of its determinations within 72 hours of receipt of expedited appeals requests.

Cause
Sponsor lacked oversight of its delegated entity and did not ensure that initial intake of expedited appeal requests were promptly forwarded to Sponsor's appeals department.

Effect
Of the 48 cases evaluated, three cases were non-compliant for late notification of coverage decisions for expedited appeal requests. Late notification causes delays in enrollees' access to urgently needed medical services.

CAP Submission 1

Project Completion Date: 11/1/2019

Org CAP Submission 1 - 9/11/2019 1:36 PM	CMS CAP Response 1 - 9/24/2019 2:13 PM
No. 7.05 To address the issue of failing to notify enrollees, and providers when appropriate, of determinations within 72 hours of receipt of expedited appeals requests, the following actions were taken: • HCSC requires eviCore to submit a daily list of all expedited cases received. The Expedited Appeals Coordinator reconciles the list of cases eviCore has sent to the inventory of cases entered into EAA. Any discrepancies are researched and addressed by the Coordinator. • HCSC developed and implemented an Expedited Appeals Tracker documenting all expedited requests received and the dates and times of each case's regulatory milestones – Receipt, Decision, Effectuation and Notification. To ensure that the issue does not reoccur, the following monitoring is in place: • Beginning November 1, 2019, HCSC will insource the intake of all pre-service appeal requests. Insourcing will allow a single point of intake, reducing the risk of late routes upon initial receipt. • The Expedited Appeals Tracker is monitored by the Expedited Appeals Coordinator. An escalation process is in place to ensure that there is adequate follow-up with staff processing the case to identify any potential barriers to timely processing and provide assistance from HCSC Management when necessary. • Twice daily, an operations inventory report is generated and reviewed by appeals management. This inventory report includes all open expedited cases and their respective compliance due date. Cases are tracked and watched to ensure that they do not age past regulatory timeframes. • On a weekly basis, overall turnaround time for expedited appeals is reported to Executive Leadership. Trends, barriers, and actions for improvement are noted.	CMS accepts this CAP.

Pages 408 through 410 redacted for the following reasons:
- -
(b)(4)

See Conditions 4.112, 4.71, 7.110, 7.113

Corrective Action Plan (CAP) Detail Report

CAP Report Search Parameters: **Program Area** = All **Finding Type** = All **CAP Phase** = All **Finding ID** = All **Element** = All

Audit ID	Parent Organization	Exit Conference Date	Entire CAP Accept Date	Entire CAP Release Date
9409	Health Care Service Corporation	9/2/2022	1/26/2023	

Program Area: Part C Organization Determinations, Appeals, and Grievances (ODAG)

Finding ID: 44402

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
44402	#4.112	Classification of Requests	Observation	CAP Released	1/26/2023	1/26/2023

Observation Language
Sponsor inappropriately dismissed requests for 16 enrollees that should have been treated as coverage requests because staff did not review all case fields when providers did not complete the clinical survey. This observation requires correction and submission of a corrective action plan (HCSC ODAG-CR_Incorrect Dismissal_RCA.zip, HCSC ODAG-CR_Incorrect Dismissal_IA.zip).

CAP Submission 1

Project Completion Date: 3/1/2023

Org CAP Submission 1 - 12/30/2022 10:29 AM	CMS CAP Response 1 - 1/10/2023 11:47 AM
To address the issue of cases being inappropriately dismissed when they should have been treated as coverage requests, the following actions have been taken: · HCSC's delegated entity, eviCore, enhanced their system to ensure the Medical Director will systematically not be allowed to dismiss a case due to a 'case basket' reflecting no CPT code. · HCSC has completed a validation of eviCore's system enhancement to ensure the controls are in place to prohibit inappropriate dismissals due to the 'case basket' issue. · eviCore has provided education to the Medical Directors regarding the system enhancement and has trained the Medical Directors on the expectations of reviewing the entire case file. · eviCore has updated their policies and procedures to ensure proper documentation of dismissal case review. To ensure that the issue does not reoccur, the following monitoring activities have been or will be implemented: · HCSC deployed monthly ODAG universe audit reviews. This universe audit identifies non-compliance with the universe data protocols. All identified issues require immediate remediation and resubmission of data in alignment with regulatory protocols. · HCSC implemented quarterly live system mock audits of eviCore to specifically review case samples, including those where the eviCore Medical Directors are making decisions. By reviewing the full case sample, including an in-depth evaluation of all systems utilized internally and externally to process cases, HCSC can identify and address any issues with use of appropriate documentation and evaluate the appropriateness of dismissed cases in the sample selection. · By 01/31/2023, HCSC will enhance the monthly clinical case file reviews of eviCore to ensure proper case handling. This monthly clinical case review is a desk file review, which assesses case handling and evaluates the appropriateness of dismissed cases.	Please revise this CAP to include more detail regarding remediation of all enrollees adversely affected by the noncompliance.

CAP Submission 2

Project Completion Date: 3/1/2023

Org CAP Submission 2 - 1/13/2023 2:16 PM	CMS CAP Response 2 - 1/26/2023 11:34 AM
To address the issue of cases being inappropriately dismissed when they should have been treated as coverage requests, the following actions have been taken: · To address the 16 enrollees whose requests were inappropriately dismissed when they should have been treated as coverage requests, HCSC has conducted a case review to determine if there was a subsequent authorization received and if members were able to access the service requested. Of the 16 members: o 15 members were confirmed to have had subsequent coverage requests submitted and approved and have received the service requested. o For the remaining member, HCSC continues to stay engaged with the provider to coordinate the review of coverage requests. HCSC attempted to outreach to the member and left direct contact information should the member need it for assistance with current or future requests. · HCSC's delegated entity, eviCore, enhanced their system to ensure the Medical Director will systematically not be allowed to dismiss a case due to a 'case basket' reflecting no CPT code. · HCSC has completed a validation of eviCore's system enhancement to ensure the controls are in place to prohibit inappropriate dismissals due to the 'case basket' issue. · eviCore has provided education to the Medical Directors regarding the system enhancement and has trained the Medical Directors on the expectations of reviewing the entire case file. · eviCore has updated their policies and procedures to ensure proper documentation of dismissal case review. To ensure that the issue does not reoccur, the following monitoring activities have been or will be implemented: · HCSC deployed monthly ODAG universe audit reviews. This universe audit identifies non-compliance with the universe data protocols. All identified issues require immediate remediation and resubmission of data in alignment with regulatory protocols. · HCSC implemented quarterly live system mock audits of eviCore to specifically review case samples, including those where the eviCore Medical Directors are making decisions. By reviewing the full case sample, including an in-depth evaluation of all systems utilized internally and externally to process cases, HCSC can identify and address any issues with use of appropriate documentation and evaluate the appropriateness of dismissed cases in the sample selection. · By 01/31/2023, HCSC will enhance the monthly clinical case file reviews of eviCore to ensure proper case handling. This monthly clinical case review is a desk file review, which assesses case handling and evaluates the appropriateness of dismissed cases.	CAP is acceptable.

Finding ID: 44355

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
44355	#4.71	Classification of Requests	Observation	CAP Released	1/26/2023	1/26/2023

Observation Language
In 42 cases, Sponsor dismissal notices included an inaccurate reason for dismissal because Sponsor miscommunicated dismissal notice requirements to one of its delegated entities. Additionally, Sponsor did not identify through routine monitoring that the same delegated entity sent notices with the inaccurate reason for dismissal. This observation requires correction and submission of a corrective action plan (CR-1, HCSC ODAG-CR_Dismissal Notice_RCA revised.zip, HCSC ODAG-CR_Dismissal Notice_IA.zip).

CAP Submission 1

Project Completion Date: 3/1/2023

Org CAP Submission 1 - 12/30/2022 10:29 AM	CMS CAP Response 1 - 1/26/2023 11:34 AM
To address the issue of the dismissal notices including an inaccurate reason for the dismissal, the following actions have been or will be taken: • HCSC has updated the dismissal template and provided finalized copies to the delegated entity, eviCore. The dismissal template included the appropriate dismissal options as outlined in accordance with Section 40.15 of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance. HCSC worked with eviCore to systematically configure the letter template and confirmed both pre- and post-implementation that the letters being sent to members are accurate (reflect the accurate dismissal option). • By 01/15/2023, HCSC will update internal policies and procedures to enhance controls to ensure letter requirements are appropriately communicated to delegates, which include clearly defining roles and responsibilities for creating, disseminating, and verifying post-production letters. End-to-end process flows on how letters are handled will be included in the updated policies and procedures. Policies and procedures will clearly define roles for providing requirements and technical assistance to the delegated entity. To ensure that the issue does not reoccur, the following monitoring activities have been or will be implemented: • HCSC deployed quarterly live system mock audits of eviCore, which includes a review of the member letters. These mock audits give HCSC an in-depth view into all systems utilized internally and externally to ensure proper case handling and to confirm letters sent to members are accurate, including the appropriate dismissal reason. • HCSC deployed quarterly audits of the approved letter templates of all its delegates to validate delegated entities are adhering to approved templates provided by HCSC. • By 01/31/2023, HCSC will enhance the monthly clinical case reviews of eviCore. This monthly clinical case review is a desk file review, which assesses case handling and evaluates member letters to confirm accuracy.	CAP is acceptable.

Program Area: Medicare Medicaid Plan - Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)

Finding ID: 43750

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
43750	#7.110	Classification of Requests	CAR	CAP Released	1/26/2023	1/26/2023

Contract Number (s)
H0927

Condition Language
Sponsor inappropriately dismissed requests that should have been treated as coverage requests or grievances.

Cause
Sponsor Medical Directors did not review all case fields in its system prior to dismissing requests when providers did not complete the clinical survey.

Effect
Sponsor identified five enrollees whose coverage requests were inappropriately dismissed.

CAP Submission 1

Project Completion Date: 3/1/2023

Org CAP Submission 1 - 12/30/2022 10:37 AM	CMS CAP Response 1 - 1/10/2023 11:47 AM
To address the issue of cases being inappropriately dismissed when they should have been treated as coverage requests, the following actions have been taken: · HCSC's delegated entity, eviCore, enhanced their system to ensure the Medical Director will systematically not be allowed to dismiss a case due to a 'case basket' reflecting no CPT code. · HCSC has completed a validation of eviCore's system enhancement to ensure the controls are in place to prohibit inappropriate dismissals due to the 'case basket' issue. · eviCore has provided education to the Medical Directors regarding the system enhancement and has trained the Medical Directors on the expectations of reviewing the entire case file. · eviCore has updated their policies and procedures to ensure proper documentation of dismissal case review. To ensure that the issue does not reoccur, the following monitoring activities have been or will be implemented: · HCSC deployed monthly SARAG universe audit reviews. This universe audit identifies non-compliance with the universe data protocols. All identified issues require immediate remediation and resubmission of data in alignment with regulatory protocols. · HCSC implemented quarterly live system mock audits of eviCore to specifically review case samples, including those where the eviCore Medical Directors are making decisions. By reviewing the full case sample, including an in-depth evaluation of all systems utilized internally and externally to process cases, HCSC can identify and address any issues with use of appropriate documentation and evaluate the appropriateness of dismissed cases in the sample selection. · By 01/31/2023, HCSC will enhance the monthly clinical case file reviews of eviCore to ensure proper case handling. This monthly clinical case review is a desk file review, which assesses case handling and evaluates the appropriateness of dismissed cases.	Please revise this CAP to include more detail regarding remediation of all enrollees adversely affected by the noncompliance.

CAP Submission 2

Project Completion Date: 3/1/2023

Org CAP Submission 2 - 1/13/2023 2:19 PM	CMS CAP Response 2 - 1/17/2023 12:42 PM
To address the issue of cases being inappropriately dismissed when they should have been treated as coverage requests, the following actions have been taken: · To address the 3 enrollees whose requests were inappropriately dismissed when they should have been treated as coverage requests, HCSC has conducted a case review to determine if there was a subsequent authorization received and if members were able to access the service requested. Of the 3 members: o 2 members were confirmed to have had subsequent coverage requests submitted and approved and have received the service requested. o For the remaining member, HCSC continues to stay engaged with the provider to coordinate the review of coverage requests. HCSC attempted to outreach to the member and left direct contact information should the member need it for assistance with current or future requests. · HCSC's delegated entity, eviCore, enhanced their system to ensure the Medical Director will systematically not be allowed to dismiss a case due to a 'case basket' reflecting no CPT code. · HCSC has completed a validation of eviCore's system enhancement to ensure the controls are in place to prohibit inappropriate dismissals due to the 'case basket' issue. · eviCore has provided education to the Medical Directors regarding the system enhancement and has trained the Medical Directors on the expectations of reviewing the entire case file. · eviCore has updated their policies and procedures to ensure proper documentation of dismissal case review. To ensure that the issue does not reoccur, the following monitoring activities have been or will be implemented: · HCSC deployed monthly SARAG universe audit reviews. This universe audit identifies non-compliance with the universe data protocols. All identified issues require immediate remediation and resubmission of data in alignment with regulatory protocols. · HCSC implemented quarterly live system mock audits of eviCore to specifically review case samples, including those where the eviCore Medical Directors are making decisions. By reviewing the full case sample, including an in-depth evaluation of all systems utilized internally and externally to process cases, HCSC can identify and address any issues with use of appropriate documentation and evaluate the appropriateness of dismissed cases in the sample selection. · By 01/31/2023, HCSC will enhance the monthly clinical case file reviews of eviCore to ensure proper case handling. This monthly clinical case review is a desk file review, which assesses case handling and evaluates the appropriateness of dismissed cases.	Please revise this CAP to include more detail regarding remediation of all enrollees adversely affected by the noncompliance. A total of five enrollees were impacted by this condition. The CAP addresses remediation for three enrollees.

CAP Submission 3

Project Completion Date: 3/1/2023

Org CAP Submission 3 - 1/18/2023 10:58 AM	CMS CAP Response 3 - 1/26/2023 11:40 AM
To address the issue of cases being inappropriately dismissed when they should have been treated as coverage requests, the following actions have been taken: · To address the 5 enrollees whose requests were inappropriately dismissed when they should have been treated as coverage requests, HCSC has conducted a case review to determine if there was a subsequent authorization received and if members were able to access the service requested. Of the 5 members: o 4 members were confirmed to have had subsequent coverage requests submitted and approved and have received the service requested. o For the remaining member, HCSC continues to stay engaged with the provider to coordinate the review of coverage requests. HCSC attempted to outreach to the member and left direct contact information should the member need it for assistance with current or future requests. · HCSC's delegated entity, eviCore, enhanced their system to ensure the Medical Director will systematically not be allowed to dismiss a case due to a 'case basket' reflecting no CPT code. · HCSC has completed a validation of eviCore's system enhancement to ensure the controls are in place to prohibit inappropriate dismissals due to the 'case basket' issue. · eviCore has provided education to the Medical Directors regarding the system enhancement and has trained the Medical Directors on the expectations of reviewing the entire case file. · eviCore has updated their policies and procedures to ensure proper documentation of dismissal case review. To ensure that the issue does not reoccur, the following monitoring activities have been or will be implemented: · HCSC deployed monthly SARAG universe audit reviews. This universe audit identifies non-compliance with the universe data protocols. All identified issues require immediate remediation and resubmission of data in alignment with regulatory protocols. · HCSC implemented quarterly live system mock audits of eviCore to specifically review case samples, including those where the eviCore Medical Directors are making decisions. By reviewing the full case sample, including an in-depth evaluation of all systems utilized internally and externally to process cases, HCSC can identify and address any issues with use of appropriate documentation and evaluate the appropriateness of dismissed cases in the sample selection. · By 01/31/2023, HCSC will enhance the monthly clinical case file reviews of eviCore to ensure proper case handling. This monthly clinical case review is a desk file review, which assesses case handling and evaluates the appropriateness of dismissed cases.	CAP is acceptable.

Finding ID: 44359

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
44359	#7.113	Classification of Requests	Observation	CAP Released	1/26/2023	1/26/2023

Observation Language
In seven cases, Sponsor dismissal notices included an inaccurate reason for dismissal because Sponsor miscommunicated dismissal notice requirements to one of its delegated entities. Additionally, Sponsor did not identify through routine monitoring that the same delegated entity sent notices with the inaccurate reason for dismissal. This observation requires correction and submission of a corrective action plan (CR-1, HCSC SARAG-CR_Dismissal Notice_RCA.zip, HCSC SARAG-CR_Dismissal Notice_IA.zip).

CAP Submission 1

Project Completion Date: 3/1/2023

Org CAP Submission 1 - 12/30/2022 10:37 AM	CMS CAP Response 1 - 1/26/2023 11:40 AM
To address the issue of the dismissal notices including an inaccurate reason for the dismissal, the following actions have been or will be taken: • HCSC has updated the dismissal template and provided finalized copies to the delegated entity, eviCore. The dismissal template included the appropriate dismissal options as outlined in accordance with Section 40.15 of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance. HCSC worked with eviCore to systematically configure the letter template and confirmed both pre- and post-implementation that the letters being sent to members are accurate (reflect the accurate dismissal option). • By 01/15/2023, HCSC will update internal policies and procedures to enhance controls to ensure letter requirements are appropriately communicated to delegates, which include clearly defining roles and responsibilities for creating, disseminating, and verifying post-production letters. End-to-end process flows on how letters are handled will be included in the updated policies and procedures. Policies and procedures will clearly define roles for providing requirements and technical assistance to the delegated entity. To ensure that the issue does not reoccur, the following monitoring activities have been or will be implemented: • HCSC deployed quarterly live system mock audits of eviCore, which includes a review of the member letters. These mock audits give HCSC an in-depth view into all systems utilized internally and externally to ensure proper case handling and to confirm letters sent to members are accurate, including the appropriate dismissal reason. • HCSC deployed quarterly audits of the approved letter templates of all its delegates to validate delegated entities are adhering to approved templates provided by HCSC. • By 01/31/2023, HCSC will enhance the monthly clinical case reviews of eviCore. This monthly clinical case review is a desk file review, which assesses case handling and evaluates member letters to confirm accuracy.	CAP is acceptable.

Pages 422 through 446 redacted for the following reasons:
- -
(b)(4)
(b)(4)

Program Area: Part C Organization Determinations, Appeals, and Grievances (ODAG)

Finding ID: 39169

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
39169	#4.52	Appropriateness of Clinical Decision-Making & Compliance with Processing Requirements	CAR	CAP Released	1/25/2021	8/2/2021

Contract Number (s)
H3916 , H3957 , H5106

Condition Language
Sponsor did not make appropriate coverage decisions for Medicare Part C required services.

Cause
Two root causes contributed to this condition. First, Sponsor's claims processors misapplied clinical criteria after misinterpreting claims images. Second, Sponsor’s delegated entity only conducted internal monitoring and required training on a quarterly basis, which affected its ability to take updated coverage criteria into account.

Effect
Sponsor identified six enrollees that were incorrectly denied medically necessary services or reimbursement.

Page 448 redacted for the following reason:
- -
(b)(4)

CAP Submission 2

Project Completion Date: 3/31/2021

Org CAP Submission 2 - 1/22/2021 1:02 PM	CMS CAP Response 2 - 1/26/2021 2:05 PM

Page 450 redacted for the following reason:
- - - - - - - - - - - - - - - - - - - -
(b)(4)

CAP Monitoring 1

Project Completion Date: 3/31/2021

Org CAP Submission 1 - 8/2/2021 10:24 AM	CMS CAP Response 1 - 8/2/2021 10:26 AM
N/A	N/A

Finding ID: 39170

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
39170	#4.39	Appropriateness of Clinical Decision-Making & Compliance with Processing Requirements	CAR	CAP Released	1/25/2021	8/2/2021

Contract Number (s)
H5106 , H3916 , H3957

Condition Language
Sponsor did not provide denial notices that used the approved notice language in a readable and understandable form including specific reasons for the denial and information regarding the enrollee's right to a reconsideration.

Cause
Sponsor used a default rationale informing the enrollee that a service was not a covered benefit. However, the denial rationale did not state the specific reason for the denial.

Effect
This condition affected enrollees in two ways. First, Sponsor identified 1,353 enrollees that received denial notifications that did not include the reason for the denial or did not tell the enrollee that the service may be covered under their Part D benefits. Second, Sponsor identified one enrollee that did not receive a denial notification letter.

Pages 453 through 454 redacted for the following reasons:
- -
(b)(4)

CAP Submission 2

Project Completion Date: 5/14/2021

Org CAP Submission 2 - 1/22/2021 1:02 PM	CMS CAP Response 2 - 1/26/2021 2:05 PM
Please refer to the 'Corrective Action Plan for ODAG Condition 4.39' in the Data Upload section attachments.	CAP appears reasonable and complete. CAP is accepted.

CAP Monitoring 1

Project Completion Date: 5/14/2021

Org CAP Submission 1 - 8/2/2021 10:24 AM	CMS CAP Response 1 - 8/2/2021 10:26 AM
N/A	N/A

Pages 457 through 484 redacted for the following reasons:
- -
(b)(4)
(b)(4)

Finding ID: 29553

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
29553	#4.39	Appropriateness of Clinical Decision-Making & Compliance with Processing Requirements	CAR	CAP Released	8/24/2018	8/1/2019

Contract Number (s)
H3154 , H8298 , H7971

Condition Language
Sponsor did not include in its denial letters adequate rationales, correct/complete information specific to denials, or language easily understandable to enrollees.

Cause
Sponsor’s denial criteria and letter logic for certain cardiology procedures incorrectly cited pediatric oncology imaging criteria.

Effect
A total of 26 enrollees received denial notifications that included incorrect criteria for the denial rationale. Inaccurate denial letters cause a lack of enrollees' understanding of the denial and impairs their ability to initiate an appeal.

CAP Submission 1

Project Completion Date:

Org CAP Submission 1 - 8/22/2018 5:13 PM	CMS CAP Response 1 - 8/24/2018 10:58 AM
On 2/15/18, Horizon updated and implemented its letter logic to include adequate rationales, and correct/complete information specific to denials, or language easily understandable to enrollees. These changes were successfully tested with a minimum of 15 cases during post production review, to validate that denial letters were pulling in the correct criteria citation for Echocardiogram - CPT 93306. On 5/14/18, a Beneficiary Impact Analysis (BIA) was submitted to Horizon and it was determined that there were 35 impacted members. To address this population, eviCore began manual development and mailing of corrected letters to all impacted beneficiaries. An outreach call was made to each of the impacted beneficiaries to inform them of the forthcoming corrected letter, and mailing was completed on 6/1/18.	This CAP appears reasonable.

Pages 487 through 536 redacted for the following reasons:
- -
(b)(4)

Finding ID: 27814

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
27814	#4.56	Timeliness	CAR	CAP Released	2/14/2018	8/20/2018

Contract Number (s)
H1304 , H1969 , H6237 , H5009 , H4605 , H5010 , H1997 , H3817

Condition Language
Sponsor did not effectuate its determinations within 72 hours of receipt of expedited reconsideration requests.

Cause
Sponsor did not have an adequate process in place to ensure that expedited determinations were effectuated in its vendor's system on weekends, holidays and after working hours. Additionally, new Sponsor staff waited for assistance to load one authorization.

Effect
Of the 56 cases evaluated, five cases were non-compliant for late effectuation of approved expedited pre-service reconsiderations. Late effectuation delays enrollees' access to needed medical services.

CAP Submission 1

Project Completion Date: 11/15/2017

Org CAP Submission 1 - 2/8/2018 8:43 PM	CMS CAP Response 1 - 2/14/2018 6:25 PM
During the audit, it was discovered that effectuation requests sent to an east coast vendor, eviCore, on Friday afternoons, Pacific Time, were not effectuating the case until Monday morning, East Coast Time. As of 11/15/17, the vendor has added supervisory coverage until 7:30 PM EST, 4:30PM PST, with their staff working on expedited items during evening, weekend and holiday hours. Cambia created an email template which provided more ease in identifying expedited effectuation cases, the subject line also includes the due date/time. The vendor had also re-educated their staff and provided Cambia team member contact information to eviCore's Appeals and Grievance supervisors and manager as well as their Client Experience Manager. This would allow any effectuation to be escalated to the plan to avoid missed timelines. Additionally, Cambia is receiving a timeliness report capturing effectuation times also allowing our team to be on high alert so we may get involved for escalation purposes.	CAP has been reviewed and deemed appropriate.

Pages 539 through 546 redacted for the following reasons:
- -
(b)(4)

Finding ID: 27801

ID	Condition #	Element	Finding Type	CAP Finding Status	Accept Date	Release Date
27801	#4.01	Timeliness	CAR	CAP Released	2/15/2018	8/20/2018

Contract Number (s)
H1304 , H1997 , H4605 , H5009 , H1969 , H3817 , H6237 , H5010

Condition Language
Sponsor did not notify enrollees, and providers if the providers requested the services, of its decisions within 72 hours of receipt of expedited organization determination requests.

Cause
Three root causes contributed to this condition. First, Sponsor did not account for the delay caused when a notification was not generated by the cutoff time for same-day mailing. Second, Sponsor staff did not follow established processes for providing notification to enrollees. Third, Sponsor's oversight of its vendor's print shop was insufficient and allowed for mailing delays.

Effect
Of the 251 cases evaluated, 22 cases were non-compliant for late notification of coverage decisions for expedited pre-service requests. Late notification causes delays in enrollees' access to needed medical services.

CAP Submission 1

Project Completion Date: 3/22/2018

Org CAP Submission 1 - 2/8/2018 8:43 PM	CMS CAP Response 1 - 2/14/2018 6:40 PM
Root Cause 1 and 2, 6 members. Cambia's Clinical Services Department is updating our internal process with our mail vendor to ensure that letters needing to be mailed same day can be accommodated to maintain timeliness. The projected date of completion is 03/01/2018. As of 1/2/18, Our vendor's, AIM, print shop has updated their process to ensure sufficient time is allocated for mailings and the vendor also instituted a new process of orally notifying members of decisions by using 3 good-faith attempts. The sponsor's business unit will be auditing timeliness compliance on a weekly basis. Root Cause 3, 16 members. The Pharmacy Services Medical Drug Review Team has implemented new processes, system tracking, and oversight to ensure compliance moving forward. A new external print vendor was implemented on 1/2/18 to deliver same day print and mail fulfillment capabilities 7 days per week and 365 per year. The vendor provides services including same day printing and mailing. The Pharmacy Services Medical Drug Review Policy and Procedure, has been updated to reflect this change. All internal departmental work instructions have been updated to reflect this change also. The vendor returns a daily log of the time and date each letter is delivered into the mail stream. The Review Team has implemented oral notification for all expedited organizational determinations as of 1/22/18. Our internal software application was upgraded on 1/2/18, to capture the time and date of such oral notification. We've hired additional full-time resources to ensure capacity for oral notifications on 100% of all expedited organizational determinations. A new internal work instruction was developed with all employees being trained as of 1/19/18. An oversight audit of 100% of all expedited organizational determinations for Medical Drug Reviews was put in effect on 1/22/18 for a period of at least 60 days. This oversight process captures all elements of the CMS timeliness review to ensure compliance. Upon the 60-day review period, a decision will be made to either extend the 100% oversight review or move the timeliness review elements into the departmental oversight monthly audit samples.	Cap is reasonable, however, Cambia needs to report to AM via email no later than 3/1/2018 on the work being done between Cambia's Clinical Services Department and mail vendor to achieve timely mailing.

CAP Submission 2

Project Completion Date: 3/22/2018

Org CAP Submission 2 - 2/15/2018 2:01 PM	CMS CAP Response 2 - 2/15/2018 2:02 PM
Root Cause 1 and 2, 6 members. Cambia's Clinical Services Department is updating our internal process with our mail vendor to ensure that letters needing to be mailed same day can be accommodated to maintain timeliness. The projected date of completion is 03/01/2018. As of 1/2/18, Our vendor's, AIM, print shop has updated their process to ensure sufficient time is allocated for mailings and the vendor also instituted a new process of orally notifying members of decisions by using 3 good-faith attempts. The sponsor's business unit will be auditing timeliness compliance on a weekly basis. Root Cause 3, 16 members. The Pharmacy Services Medical Drug Review Team has implemented new processes, system tracking, and oversight to ensure compliance moving forward. A new external print vendor was implemented on 1/2/18 to deliver same day print and mail fulfillment capabilities 7 days per week and 365 per year. The vendor provides services including same day printing and mailing. The Pharmacy Services Medical Drug Review Policy and Procedure, has been updated to reflect this change. All internal departmental work instructions have been updated to reflect this change also. The vendor returns a daily log of the time and date each letter is delivered into the mail stream. The Review Team has implemented oral notification for all expedited organizational determinations as of 1/22/18. Our internal software application was upgraded on 1/2/18, to capture the time and date of such oral notification. We've hired additional full-time resources to ensure capacity for oral notifications on 100% of all expedited organizational determinations. A new internal work instruction was developed with all employees being trained as of 1/19/18. An oversight audit of 100% of all expedited organizational determinations for Medical Drug Reviews was put in effect on 1/22/18 for a period of at least 60 days. This oversight process captures all elements of the CMS timeliness review to ensure compliance. Upon the 60-day review period, a decision will be made to either extend the 100% oversight review or move the timeliness review elements into the departmental oversight monthly audit samples.	Cap is reasonable, however, Cambia needs to report to AM via email no later than 3/1/2018 on the work being done between Cambia's Clinical Services Department and mail vendor to achieve timely mailing.

Pages 550 through 568 redacted for the following reasons:
- -
(b)(4)

See Condition 4.4.2.4

PacificSource Community Health Plans, Inc.
2965 NE Conners Avenue, Bend OR 97701
541.385.5315 888.863.3637
Medicare.PacificSource.com

APPENDIX A – CAR RESPONSES

PART C ORGANIZATION DETERMINATION APPEALS AND GRIEVANCES (ODAG)

Audit Element	Condition #	Corrective Action Required	Corrective Action Summary	Timeframe for Correction
ODAG – Clinical Decision Making	4.4.2.1	Sponsor must ensure that Medicare covered services are reimbursed appropriately.	The plan is updating written procedures to reflect the guidance on hospice transport that went into effect on 8/4/14 per Benefit Policy Manual Ch. 9 section 40.1.9. Staff training and education has occurred on the new guidance. The claims department has issued an internal memo on the new process to all claims analysts. Additionally, group and one-on-one trainings have occurred with claims staff. As a result, claims for ambulance transport to the members home or hospice facility on the same day as the hospice election are processing as a Medicare covered service. The Compliance team is currently validating the correction of the issue via weekly analysis of claims reports and case samples. Ongoing monitoring will occur to verify accuracy of claim payment and denials.	3/6/2015
ODAG – Clinical Decision Making	4.4.2.2	Sponsor must ensure that denial letters are complete and accurate, including an adequate rationale specific to the	The plan is updating procedures and providing staff training to ensure denial letter content is in accordance with CMS guidance. Letters will be accurate, clear and include detailed information related to the specific reason(s) for the denial, how the service may be covered and include the applicable Medicare coverage rule or plan policy. Letters will be written in a	4/30/15

		denial.	manner that is understandable to members. Staff training has occurred at a group level within the Health Services Department. Subsequent to staff training, the plan has implemented a peer review process to further ensure denial letters are compliant prior to sending to members. Concurrently, the plan is working with its delegated entity, AIM, on implementing the same standards for denial letter content. AIM has undergone a reorganization to dedicate resources solely to the Medicare line of business with the intent of providing overall better outcomes related to Medicare requirements including denial letters. More specifically, the AIM government program review team underwent group classroom training, which included review of standard denial wording based on language found in the coverage determinations. This training occurred on 12/10/2014 with RN and Interceptor staff and on 12/17/2014 with physicians. Ongoing denial documentation updates, in partnership with AIM legal and compliance departments, occur as additional denial scenarios are encountered during the course of day to day review. As such, ad hoc ongoing training will occur as needed. Overall broad revision improvements to AIM denial letter content was implemented on 12/20/14 via system update and incorporation into processes. As part of the overall process improvements, AIM began monitoring of Medicare denial rationale on 1/1/15. This monitoring currently includes a review of 100% of all Medicare denials. The Compliance team is currently validating the correction of the issue. Compliance receives weekly organization determination data from internal and AIM sources. Analysis of a sample of cases occurs for compliance with denial letter requirements. Lastly, ongoing monitoring of both internal and delegated entity denial letters will occur to validate maintenance of compliance.	
ODAG – Clinical	4.4.2.3	Sponsor must ensure that	The plan has added thorough non-contract provider appeal rights to	2/28/2015

Decision Making		the remittance advice/notices contain the required information, including provider appeal rights regarding a denied payment request.	provider remittance notices that include all elements stated in the Medicare Managed Care Manual Ch. 13 section 40.2.3. Additionally, the plan is updating systems to ensure all appropriate denial codes are set up to trigger population of denial reason language on provider remittance notices. The Compliance team is sampling denied claims and corresponding remittance notices on a weekly basis to ensure inclusion of non-contract provider appeal rights and denial reasons. Ongoing monitoring will occur to ensure that remittance notices include denial reasons and complete non-contract provider appeal rights.	
ODAG – Clinical Decision Making	4.4.2.4	Sponsor must perform sufficient outreach to the prescriber or beneficiary to obtain additional information necessary to make an appropriate clinical decision.	The plan is updating written procedures on provider outreach, implementing the accepted industry standard of a minimum of 3 distinct outreaches. The plan has distributed new desktop procedures and provided group information and training sessions on the new process. Concurrently, the plan is working with its delegated entity, AIM, on implementing the same standards for provider outreach. AIM has undergone a reorganization to dedicate resources solely to the Medicare line of business to provide overall better outcomes related to Medicare requirements. As of 1/1/15 a second provider outreach attempt for cases headed down a denial path was implemented by AIM. This second contact is queued up systematically based on case status and is handled as a call to the provider. The staff that handles callouts was trained on this topic on 12/18/14 and an internal notification was sent out on 1/2/15 to the clinical operations staff to educate them about the second contact for all Medicare cases. The addition of a third outreach attempt is underway and will be implemented in association with the 4/18/15 system update. AIM operations is setting up staff support and processes to track cases and make outreach attempts on needed cases. Once the third outreach process is in	4/30/15

			place, the second outreach contact will be changed to a fax, with any failed faxes dropping to a queue for a call. The third outreach attempt will be a direct call to the provider. AIM will send a report on a monthly basis to PacificSource noting those cases on which multiple outreach contacts were made but in which no additional information was received from the provider so that feedback or additional education can be given. The Compliance team is currently validating the correction of the issue. Compliance receives weekly organization determination data from internal and AIM sources. Compliance analyzes a sample of cases to determine if sufficient outreach was performed. Lastly, the plan will perform ongoing monitoring of both internal and delegated entity organization determinations to verify that the process is sufficient in obtaining the needed additional information.	
ODAG – Grievances	4.4.3.1	Sponsor must resolve grievances within CMS required timeframes.	The Grievance and Appeals Department has taken the following steps to correct the observed conditions. **<u>Improvements to system efficiencies:</u>** The G&A department has converted to a new online/paperless system that promotes efficiencies. The following are examples: •All grievance documentation is attached to each case for easy access and review by the physician. •Once the development of the case file (e.g. records access) has been completed by the analyst, it is assigned within the system to a physician for review. •A deadline is identified in the system for clear view by the physician. •The physician findings are documented in an online form that is attached to the electronic case file. •The record and status is visible to both physician and analyst online. •The case file's completion status is updated in the system in real time and the analyst can then complete her/his steps. •The online system calculates all deadlines and is color-coded to provide a 'warning' when the deadline is becoming due.	4/17/2015

			<u>Improvements in training:</u> •Step by step processes are documented for both analysts and physicians for their use in processing QOC grievances. This includes not sending the resolution notice until the complete conclusion of all grievance investigations. •The G&A Manager has provided one-on-one and group training to physician reviewers and analysts regarding the process and timelines. **<u>Staffing resourcing:</u>** •We have added physicians to the review process and designated different physician staff to be responsible for QOC reviews. • Staff has been added to the G&A Department and an SME has been assigned to these grievance resolutions for consistency and accountable oversight. •Back up staff has been assigned to the SME to ensure ample coverage at all times. The Compliance team is receiving grievance data and performing weekly validation on grievance timeliness to ensure correction of the issues. Ongoing monitoring of grievance processing will occur to ensure continued compliance.	