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

MICHELLE BAASS
DIRECTOR

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May 23, 2022

Yasamin Hafid, Chief Compliance Officer
Blue Shield of California Promise Health Plan
601 Potrero Grande Drive
Monterey Park, CA 91755

RE: Department of Health Care Services Medical Audit

Dear Ms. Hafid:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Blue Shield of California Promise Health Plan, a Managed Care Plan (MCP), from February 22, 2021 through March 5, 2021. The audit covered the period of January 1, 2020 through December 31, 2020.

On May 17, 2022, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on June 22, 2021.

All items have been evaluated and DHCS accepts the MCP's submitted CAP. The CAP is hereby closed. Overall effectiveness of the CAP will continue to be assessed, as well as, to what extent the MCP has operationalized proposed corrective actions on the subsequent audit. The enclosed report will serve as DHCS' final response to the MCP's CAP.

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

If you have any questions, feel free to contact me at (916) 345-7825 or Anthony Martinez at (916) 345-7828.

Sincerely,

[Signature on file]

Oksana Meyer, Chief
CAP Compliance and FSR Oversight Section
Managed Care Quality and Monitoring Division
Department of Health Care Services

Enclosures: Attachment A, CAP Response Form

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

ATTACHMENT A
2021 Corrective Action Plan Response Form

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Plan: Blue Shield of California Promise **Review Period: 01/01/2020 – 12/31/2020**

Audit Type: Medical Audit and State Supported Services **Onsite Review: 02/ 22/2021 – 03/05/2021**

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

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. For deficiencies that require short-term corrective action, implementation should be completed within 30 calendar days. For deficiencies that require long-term corrective action or a period longer than 30 calendar days for implementation, the MCP must demonstrate it has taken remedial action and is making progress toward achieving an acceptable level of compliance. The MCP will be required to include the date when full compliance is expected to be achieved. **Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval, as applicable in accordance with existing requirements.**

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

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
1. Utilization Management				
1.1.1 Integration of Utilization Management with Quality Improvement The Plan did not	The Utilization Management (UM) team tracks and reports out on the number and types of appeals and prior authorization denials, deferrals, and	**1.** Utilization Management Program Description **2.** 70.2.50 Prior	**1.** Completed July 14, 2021 **2.** Completed July 14, 2021	**07/26/21** - The following documentation supports the MCP's efforts to correct this finding: 1. Utilization Management

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integrate review of prior authorization and appeal reports into its QIS.	modifications. 1. The UM team updated the UM Program Description to specifically note the need to track the number and types of prior authorization appeals, denials, deferrals, and modifications and report these metrics to the Medical Services Committee (MCS) and Quality Management Committee (QMC). ***(1. Utilization Management Program Description)*** 2. The team updated its prior authorization policy to describe how this information and other key metrics flow from the MCS to the QMC. ***(2. 70.2.50 Prior Authorization)*** 3. Both Utilization	Authorization **3.** Medical Services Committee Meeting Deck **4.** A) UM workplan PHP_Q2 2021_SD_Pgs 3 and 10 B) Q3 2021 MSC DECK 9.23.21 ABRIDGED_pg 15 18 19 C) Blue Shield Promise QMC Binder_10-27-2021 V3	**3.** Completed June 21, 2021 **4.** A) Completed August 31, 2021 B) Completed September 23, 2021 C) Completed October 27, 2021	Program Description - The Plan updated its UM Program Description to specifically note the need to track the number/types of prior authorization appeals, denials, deferrals, and modifications. The Plan also included reporting these metrics to the Medical Services Committee (MCS) and Quality Management Committee (QMC). 2. 70.2.50 Prior Authorization – The Plan's Utilization Management team updated its prior authorization policy to include the proper information/key metrics & how the flow between MCS to the QMC. 3. Medical Services Committee Meeting Deck – The Plan's Utilization Management & Appeals and Grievance data have been collected & since been presented at the Medical Services Committee

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	Management and Appeals and Grievance data were collected and presented at the Medical Services Committee (MSC) meeting on June 21, 2021. The types of prior authorization appeals, denials, and modifications were addressed in the June meeting. ***(3. Medical Services Committee Meeting Deck)*** *4.* The additional utilization metrics are being incorporated into the UM Workplan (A) and will be reported out to the MSC on September 23, 2021 (B). These metrics will be presented at the Quality Management Committee (QMC) (C) meeting on October 27, 2021. ***(4. A) UM workplan PHP_Q2 2021_SD_Pgs 3 and 10, B) Q3 2021 MSC DECK 9.23.21***			(MSC) meeting on June 21, 2021. The Plan went over the types of prior authorization appeals, denials, & modifications at the June meeting. The Plan provided its meeting slide deck from this meeting. 4. The Utilization Management Program Description & 70.2.50 Prior Authorization were updated & implemented July 14, 2021. Both documents reflect the above noted additions. The UM Workplan that will include additional utilization metrics will be reported to the MSC on September 23, 2021 & will also be presented at the QMC meeting on October 27, 2021. DLP will be created by September 1, 2021. **This finding is closed.**

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	ABRIDGED_pg 15 18 19, C) Blue Shield Promise QMC Binder_10-27-2021 V3			
1.1.2 Specialty Referrals Tracking System The Plan did not use its Specialty Referral Tracking System to ensure that members receive services within the required 15-business-days of request.	Blue Shield of California Promise Access and Availability, Utilization Management, and Provider Relations teams work collaboratively to ensure that the Plan's members receive appointments with specialty providers within 15 business days of the request. 1. The teams that focus on Accessibility and Availability use the Provider Appointment Availability Survey (PAAS) to ensure timely access to specialty services. The survey polls select providers about their ability to offer members urgent and routine appointments for primary and specialty	**2.** 2020 (PAAS) Survey Tool **3.** Secret Shopper Program Proposal **4.** Specialty Tracking 15 Day Report **5.** 70.2.99 Specialty Tracking and Monitoring **6.** 70.2.7 Specialty Care Referral Manageme	**1.** Completed June 2, 2021 **2.** Completed July 1, 2021 **3.** Completed September15, 2021 **4.** Completed July 14, 2021 **5.** Completed July 14, 2021 **6.** Completed December 31, 2021 **7.** Completed July 14, 2021	**07/26/21** - The following documentation supports the MCP's efforts to correct this finding: 1. 2020 (PAAS) Survey Tool – The Plan's team(s) that focus on Accessibility and Availability use the Provider Appointment Availability Survey (PAAS) to ensure timely access to specialty services. This survey polls select providers about their ability to offer members urgent & routine appointments for primary/specialty services. 2. Secret Shopper Program Proposal – The Plan identifies the providers who have poor PAAS results from the survey. These providers

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	care. This effort assesses specialty service provider appointments. ***(1. 2020 (PAAS) Survey Tool)*** 2. Providers who have poor PAAS results may be subject to a Secret Shopper Program that began on July 1, 2021. The Secret Shopper Program uses outbound call survey methodologies to collect and evaluate access-related data directly from a sample set of targeted provider groups/IPAs to determine whether appointment availability is improving for our members over time. An overview of the secret shopper programs is attached. ***(2. Secret Shopper Program Proposal)*** **1.** The Utilization	nt **7.** 70.2.99 Specialty Tracking and Monitoring **8.** 70.2.99 Specialty Tracking and Monitoring		may be subject to a Secret Shopper Program that the Plan began on July 1, 2021. The Secret Shopper Program uses outbound call surveys to collect/evaluate access-related data from a direct sample set of targeted provider groups/IPAs to determine whether appointment availability is improving for our members over time. The Plan provided an overview of the secret shopper program. 3. 70.2.99 Specialty Tracking and Monitoring – The Plan's Utilization Management Analytics team offers specialty tracking reports that cite the percentage of specialty services appointments requiring prior authorization that met/did not meet the 15 business day requirement based on authorization and claims data. The Plan's report example is in progress. The

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	Management Analytics team offers specialty tracking reports that cite the percentage of specialty services appointments requiring prior authorization that met/did not meet the 15 business day requirement based on authorization and claims data. Report example is in progress. ***(3. Specialty Tracking 15 Day Report)*** 3. The UM team updated the UM *Specialty Tracking and Monitoring* (70.2.99) policy and procedure to reflect the 15 business day appointment tracking report process. ***(4. 70.2.99 Specialty Tracking and Monitoring)*** 4. The UM team also corrected the *Specialty Care Referral Management (70.2.7)*			Plan's corrective action(s) address the root cause of this finding and if fully implemented should resolve this matter 4. 70.2.7 Specialty Care Referral Management – The Plan's Utilization Management team updated the UM *Specialty Tracking and Monitoring* (70.2.99) policy and procedure to reflect the 15 business day appointment tracking report process. 5. 70.2.99 Specialty Tracking and Monitoring – The Plan's UM team revised its *Specialty Care Referral Management (70.2.7)* policy & procedure to reflect the 15 business day appointment requirement. 6. 70.2.99 Specialty Tracking and Monitoring – The Plan determined based on a combination of PAAS, Secret

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	policy and procedure to reflect the 15 business day appointment requirement. ***(5. 70.2.7 Specialty Care Referral Management)*** *5.* If, based on a combination of PAAS, Secret Shopper program data, and UM Specialty Tracking reports, it is determined that specialty physicians are not regularly meeting the scheduling standards, Provider Relations will be engaged to discuss the deficiencies with the physician/medical group and would potentially place them on a corrective action plan so that they can improve appointment availability. ***(6. 70.2.99 Specialty Tracking and Monitoring*** 6. Specialty Referral Tracking information will			Shopper program data, & UM Specialty Tracking reports, that specialty physicians were not regularly meeting the scheduling standards. The Plan's Provider Relations will be discussing the deficiencies with the physician/medical group & possibly place them on a corrective action plan in order to improve appointment availability. The Plan's corrective action(s) address the root cause of this finding and if fully implemented should resolve this matter 7. 70.2.99 Specialty Tracking and Monitoring – The Plan will be sharing the Specialty Referral Tracking information at the September Medical Services Committee (MSC) and at least annually thereafter. **This finding is closed.**

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	be shared at the September Medical Services Committee (MSC) and at least annually thereafter. ***(7. 70.2.99 Specialty Tracking and Monitoring)***			
1.1.3 Medical Director Involvement in the Grievance Process The Plan's Medical Director did not actively participate in the Plan's grievance and appeal process.	1. *Beneficiary Grievance Management System* (policy number 10.19.15) provides a detailed overview of the grievance system. The policy outlines the process of maintaining and ensuring the members rights. The policy and procedure (P&P) was updated on June 30, 2021.The update includes the description of the Promise Health Plan Chief Medical Officer's (PHP CMO or Medical Director designee) review and approval of P&P updates and their overall oversight of grievance functions. ***(1. 10.19.15 Beneficiary Grievance Management System)*** 2. PHP CMO or Medical Director designee oversight	**1.** 10.19.15 Beneficiary Grievance Management System **2.** Grievance Log Template **3.** A) 10.19.15 Beneficiary Grievance Management System B) Medical Director AG Case Review Meeting Materials C) AGD Org Chart	**1.** Completed June 30, 2021 **2.** Completed July 21, 2021 **3.** A) Completed June 30, 2021 B) Completed July 21, 2021 C) Completed July 23, 2021 **4.** Completed June 30, 2021 **5.** Completed August 20, 2021	**07/26/21** - The following documentation supports the MCP's efforts to correct this finding: **1.** 10.19.15 Beneficiary Grievance Management System revised to include procedures for PHP CMO or Medical Director designee to review and approve of P&P updates on oversight of grievances. It provides a detailed overview of the grievance system. The policy outlines the process of maintaining and ensuring the members rights. **2.** Grievance Log Template. PHP CMO or Medical

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	includes a monthly audit of the grievance cases randomly selected from the grievance log. This monthly audit will focus on the following: • Appropriate identification of all issues and proper case categorization of non-clinical, clinical, and potential quality issues. • Appropriate resolution, including but not limited to addressing the members' specific concerns, whether clinical grievances were forwarded to a Medical Director appropriately, and whether all aspects of the grievance were resolved appropriately. ***(2. Grievance Log Template)*** 3. The Plan has established a monthly meeting with the PHP CMO or Medical Director designee, Clinical staff and	**4.** 10.19.15 Beneficiary Grievance Management System **5.** Grievance Log Audit DLP_MediCal_ 082021		Director designee oversight includes a monthly audit of the grievance cases randomly selected from the grievance log. This monthly audit will focus on the appropriate identification of all issues and proper case categorization of non-clinical, clinical, and potential quality issues, as well as appropriate resolution. The Plan has established the monthly meeting with the PHP CMO or Medical Director designee, Clinical staff and Appeals and Grievances staff to review the findings of the grievance log audit. The PHP CMO is the chair of the Plan's quarterly quality assurance committee known as the Medical Services committee (MSC). The monthly audit findings are

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	Appeals and Grievances staff to review the findings of the grievance log audit. The purpose of this meeting includes but is not limited to ensuring appropriate action has been taken such as coaching, feedback, corrective action, and ongoing process improvement. This process is outlined in the updated P&P *Beneficiary Grievance Management System* (policy number 10.19.15) ***(3. A) 10.19.15 Beneficiary Grievance Management System, B) Medical Director AG Case Review Meeting Materials, C) AGD Org Chart)*** 4. The PHP CMO is the chair of the Plan's quarterly quality assurance committee known as the Medical Services committee (MSC). The monthly audit findings are reported at the MSC and reported at the Plan's Board committee, known as the Board Quality Improvement Committee			reported at the MSC and reported at the Plan's Board committee, known as the Board Quality Improvement Committee (BQIC). This process ensures broad leadership review and oversight of all grievance audit findings and actions. This process is outlined in the updated P&P, Beneficiary Grievance Management System (policy number 10.19.15). **3.** A) 10.19.15 Beneficiary Grievance Management System B) Medical Director AG Case Review Meeting Materials C) AGD Org Chart **4.** 10.19.15 Beneficiary Grievance Management System

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	(BQIC). This process ensures broad leadership review and oversight of all grievance audit findings and actions. This process is outlined in the updated P&P, Beneficiary Grievance Management System (policy number 10.19.15). ***(4. 10.19.15 Beneficiary Grievance Management System)*** 5. A Desk Level Procedure (DLP) will be created that outlines the grievance log audit steps and process. ***(5. Grievance Log Audit DLP_MediCal_082021)***			**8/25/2021**- the MCP submitted additional documentation, A Desk Level Procedure (DLP) that outlines the overall grievance log audit steps and process. **5.** Grievance Log Audit DLP Supporting documentation outlines the Plan's Chief Medical Officer or designated Medical Director's involvement in the Plan's grievance system, including revised policies and procedures, monthly audits and monthly meetings with clinical staff and grievance and appeals staff. **The finding is closed.**
1.1.4 Medical Decisions in the Grievance Process The Plan's Medical Director did not ensure that member	1. Beneficiary Grievance Management System (policy number 10.19.15) provides a detailed overview of the grievance system. The policy outlines the process of maintaining and ensuring the	**1.** 10.19.15 Beneficiary Grievance Management System **2.** Grievance Log	**1.** Completed June 30, 2021 **2.** Completed July 21, 2021 **3.** A) Completed	**07/26/21** - The following documentation supports the MCP's efforts to correct this finding: **1.** 10.19.15 Beneficiary

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grievances involving clinical issues were properly classified and reviewed by qualified medical personnel.	member rights. The policy and procedure (P&P) was updated on June 30, 2021. The update reflects that the PHP CMO has delegated responsibility to the PHP Medical Director for clinical oversight to ensure member grievances are properly classified and reviewed by qualified medical personnel. ***(1. 10.19.15 Beneficiary Grievance Management System)*** 2. PHP CMO or Medical Director designee oversight includes a monthly audit of grievance cases randomly selected from the grievance log. This monthly audit will focus on the following: • Appropriate identification of all issues and proper case categorization of non-clinical, clinical, and potential quality issues.	Template **3.** A) 10.19.15 Beneficiary Grievance Management System B) Medical Director AG Case Review Meeting Materials C) AGD Org Chart **4.** 10.19.15 Beneficiary Grievance Management System **5.** Grievance Log Audit DLP_MediCal_ 082021 **6.** 10.19.15 Beneficiary	June 30, 2021 B) Completed July 21, 2021 C) Completed July 23, 2021 **4.** Completed July 20, 2021 **5.** Completed August 20, 2021 **6.** Completed June 30,2021	Grievance Management System **2.** Grievance Log Template **3.** A) 10.19.15 Beneficiary Grievance Management System B) Medical Director AG Case Review Meeting Materials C) AGD Org Chart **4.** 10.19.15 Beneficiary Grievance Management System **8/25/2021**- the MCP submitted additional documentation, A Desk Level Procedure (DLP) that outlines the overall grievance log audit steps and process. **5.** Grievance Log Audit DLP **6.** 10.19.15 Beneficiary Grievance Management

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	• Appropriate resolution, including but not limited to addressing the members' specific concerns, whether clinical grievances were forwarded to the PHP CMO or Medical Director designee appropriately, and whether all aspects of the grievance were resolved appropriately. ***(2. Grievance Log Template)*** 3. The Plan has established a monthly meeting with the PHP CMO or Medical Director designee, Clinical staff and Appeals and Grievances staff to review the findings of the grievance log audit. The purpose of this meeting includes but is not limited to ensuring appropriate action has been taken such as coaching, feedback, corrective action, and ongoing process improvement. This process is outlined in the updated P&P,	Grievance Management System		System The Plan's corrective action has addressed the deficiencies outlined in the audit report. The Plan's Medical Director has been delegated responsibility for clinical oversight of the grievance system which will ensure proper classification (QOC v. QOS), identification of quality issues and provides for real time clinical oversight by licensed healthcare professionals. *The Beneficiary Grievance Management System* (policy number 10.19.15) provides a detailed overview of the grievance system. The policy outlines the process of maintaining and ensuring the member rights. The policy and procedure (P&P) was updated on June 30, 2021. The update reflects that the PHP CMO has delegated responsibility to the PHP Medical Director for clinical oversight to ensure member

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	Beneficiary Grievance Management System (policy number 10.19.15). ***(3. A) 10.19.15 Beneficiary Grievance Management System, B) Medical Director AG Case Review Meeting Materials, C) AGD Org Chart)*** 4. The PHP CMO is the chair of the Plan's quarterly quality assurance committee known as the Medical Services committee (MSC). The monthly audit findings will be reported at the MSC and also reported at the Plan's Board committee, known as the Board Quality Improvement Committee (BQIC). This process ensures broad leadership review and oversight of all grievance audit findings and actions. This process is outlined in the updated P&P, Beneficiary Grievance Management System (policy number 10.19.15). ***(4. 10.19.15 Beneficiary Grievance Management System)***			grievances are properly classified and reviewed by qualified medical personnel. PHP CMO or Medical Director designee oversight includes a monthly audit of grievance cases randomly selected from the grievance log. This monthly audit will focus on appropriate identification of all issues and proper case categorization of non-clinical, clinical, and potential quality issues as well as resolution utilized in the Grievance Log Template. The Plan has established a monthly meeting with the PHP CMO or Medical Director designee, Clinical staff and Appeals and Grievances staff to review the findings of the grievance log audit. The purpose of this meeting includes but is not limited to ensuring appropriate action has been taken such as coaching, feedback, corrective action, and ongoing process improvement

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	5. A Desk Level Procedure (DLP) will be created that outlines the overall grievance log audit steps and process ***(5. Grievance Log Audit DLP_MediCal_082021)*** 6. Implement real-time clinical oversight by licensed healthcare professionals. This clinical oversight will include the review of all cases to determine the accuracy of case categorization and ensure clinical issues are appropriately identified. Feedback and corrective action will occur in real-time. The Policy and Procedure (P&P), *Beneficiary Grievance Management System* (policy number 10.19.15) will be updated to document this process. ***(6. 10.19.15 Beneficiary Grievance Management System)***			The PHP CMO is the chair of the Plan's quarterly quality assurance committee known as the Medical Services committee (MSC). The monthly audit findings will be reported at the MSC and also reported at the Plan's Board committee, known as the Board Quality Improvement Committee (BQIC). This process ensures broad leadership review and oversight of all grievance audit findings and actions. This process is outlined in the updated P&P, Beneficiary Grievance Management System (policy number 10.19.15). A Desk Level Procedure (DLP) is in process that outlines the overall grievance log audit steps and process. They will implement real-time clinical oversight by licensed healthcare professionals. This clinical oversight will include the review of all cases to determine the accuracy of case categorization and ensure clinical issues are appropriately identified.

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				Feedback and corrective action will occur in real-time. **The finding is closed.**
3. Access and Availability of Care				
3.8.1 Physician Certification Statement The Plan did not utilize the required DHCS-approved PCS forms to determine the appropriate level of service for Medi-Cal members.	1. In February 2021, the Utilization Management intake team updated its processes to more aggressively push for providers to complete a treatment authorization request (TAR) and submit the required Physician Certification Services (PCS) form. They further refined processes to close performance gaps March, May, and June to further promote compliance. ***(1. A) Updated Non-Emergency Medical Transport Process PCS Form and TAR Required Prior to Case Creation, B) Attach Completed PCS Form to the Case, C) Updated Promise New Process for Non-***	**1.** A) Updated Non-Emergency Medical Transport Process PCS Form and TAR Required Prior to Case Creation B) Attach Completed PCS Form to the Case C) Updated Promise New Process for Non-Emergency Medical Transportation	**1.** A) Completed February 17, 2021 B) Completed March 19, 2021 C) Completed May 1, 2021 **2.** Completed March 1, 2021 **3.** A) Completed April 22, 2021 B) Completed April 22, 2021 **4.** A) Completed April 1, 2021 B) Completed	**07/26/21** - The following documentation supports the MCP's efforts to correct this finding: - Updated NEMT Process instructs that coordinators will no longer build a case for NEMT request without a TAR and a provider signed PCS form. Coordinators will send faxes to requesters for requests that are made without these items stating that they must be included for the MCP to proceed in making a case for review and determination. - Fast Track Communication instructing on the required attachment of completed PCS forms to the case.

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	Emergency Medical Transportation Requests) 2. On 3/1. Plan staff began an outreach campaign to members' medical group via phone call and email. The outreach was done to request submission of PCS forms for members who had reoccurring/standing NEMT services already scheduled. ***(2. Script 1)*** 3. In late March, the Customer Service team altered its processes and trained staff that the Plan will no longer schedule appointments for NEMT services without a current TAR and PCS form. ***(3. A) CS Process, B) CS Training)*** 4. From 4/1- 4/7, outreach was done to all members with reoccurring/standing rides to inform them that as of 4/16 their rides would be cancelled unless their	Requests **2.** Script 1 **3.** A) CS Process B) CS Training **4.** A) Script 2 B) Script 3 **5.** Script 4 **6.** PCS Form and Approval **7.** PCS to Coaching Report **8.** PCS Compliance Report **9.** 10.2.44 Non-Emergency Medical Transportation Services	April 9,2021 **5.** Completed April 14,2021 **6.** Completed April 20,2021 **7.** Completed May 1,2021 **8.** Completed May 1,2021 **9.** Completed July 14,2021	- Updated Promise New Process for NEMT Requests contains overview of process requiring signed PCS form, TAR and supporting documentation. Also includes process for when requests are submitted without the required documentation. - Outreach script used to contact members' medical groups to request for and the method for sending PCS forms to the MCP. The scripts explains the MCP's requirement for signed PCS forms in order to authorize NEMT. - Transportation Service Process and Training have been update to not allow the scheduling of NEMT trips without a PCS form on file. - Scripts for member and facility outreach to inform that standing rides would be cancelled if PCS form and TAR not received from provider.

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	prescribing doctor sent in the required PCS form and TAR. ***(4. A) Script 2).*** On 4/9, outreach began to all facilities that had members with reoccurring orders to request facility support with obtaining PCS form and TAR. ***(4. B) Script 3)*** 5. On 4/14, in an effort to limit member access to care concerns and possible harm to members, the Plan temporarily delayed the service cancellation order for certain members. These were members with standing orders who would likely face adverse health outcomes if their rides were cancelled. Simultaneously, the Plan engaged in a coordinated outreach campaign to members and providers with standing referrals but no PCS/TAR noting the importance of compliance. In April, 283 members with reoccurring			- Script for obtaining required documentation from providers to continue standing NEMT services for members. - Approved PCS form submitted by MCP. Form approved by DHCS 6/15/21. - Example of PCS Coaching report demonstrates the MCP is monitoring its staff for the inclusion of PCS forms when processing NEMT. - PCS Compliance Report demonstrates the MCP is improving its compliance rate with the PCS process. Going from 5% in January 2021 to 92% in June 2021. - Updated Transportation Policy describes the MCP's monitoring process which includes the reporting of PCS compliance rates to the UM Committee. 10/15/21 - The following additional documentation

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	orders were without PCS forms on file. The number was reduced to 137 in May. After a follow up outreach campaign in June, the number fell to 115. The Plan will continue to work with providers until all relevant forms are received. ***(5. Script 4)*** 6. On 4/20/21, the PCS form was submitted to DHCS for approval, and approval was received on 6/15/2021. ***(6. PCS Form and Approval)*** 7. On 5/1/21, Utilization Management leadership began using enhanced authorization system reports to identify staff who processed authorizations without PCS forms. The report is reviewed at least weekly. Staff who authorized services without PCS forms received coaching. ***(7. PCS to Coaching Report)***			supports the MCP's efforts to correct this finding: - PCS Compliance Reports from July and August show the MCP's rate of PCS forms continues to be over 90%. - Policy 10.2.44 references the MCP's new PCS form. 11/15/21 - The following additional documentation supports the MCP's efforts to correct this finding: - CE Alert for PCS and TAR forms consolidation demonstrates the MCP updated its staff on the new process. - Provider Email and Fax Communication demonstrates that the MCP has informed its network providers of its redesigned PCS form. The Plan made updates to instruct coordinators no longer build a case for NEMT request

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	8. A related report displays overall compliance with the PCS process. The report is reviewed at least monthly. The report shows a steady increase in compliance. In January, only 5% of authorizations had current PCS forms. From April through June, the percent of authorizations with active PCS forms was at 95%. ***(8. PCS Compliance Report)*** 9. NEMT PCS compliance rates will be reported to UM leadership at least monthly. It will also be reported to the September Medical Services Committee (MSC) and go to committee at least annually thereafter***. (9. 10.2.44 Non-Emergency Medical Transportation Services)*** 10. In September, the Plan has prepared a revised PCS form to combine the TAR and PCS			without a TAR and a provider signed PCS form. Staff will send faxes to the requester if these items are not included stating the Plan will not proceed. The Plan began an outreach campaign to medical groups to request submission of PCS forms for members who standing NEMT service already scheduled. Customer service staff was trained on this new process in March. From 4/1/21-4/7/21 the Plan conducted member outreach to members with reoccurring rides in inform the rides would be cancelled unless their doctor sent in the PCS form and TAR. The Plan temporarily delayed service cancellation to certain members to prevent adverse outcomes The Plan reduced reoccurring NEMT order from 283 in April to 34 in August. UM leadership began using enhance authorization report to identify staff that is processing requests without PCS forms. Reports are viewed on a weekly basis. The

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	into one. This will streamline the submission process for providers. This will also simplify the Plan's intake and authorization process in order to achieve compliance. The Plan has submitted this revision for DHCS contract manager approval on 9/13/21." (10. ***BSCPHP NEMT PCS Form***) 11. UM Staff will receive Fast Track Communication training with sample of new form after DHCS approval and before form is published online. (***11. Fast Track Communication (FTC)NEMT Process Updates 11_05_2021_)*** 12. UM will update the P&P to reference the new form after DHCS approval and before form is published online. ***(12. 10.2.44 Non-Emergency Medical Transportation)*** 13. Customer Care staff will receive updated process			Plan uses a related report that displays overall compliance. They went from a compliance rate of 5% in January to 95% in June. PCS compliance rates are reported to UM leadership at least monthly and the Medical Services Committee at least annually. In September the Plan creates a revised PCS TAR combo form which was approved by the DHCS contract manager on 9/13/21. UM staff was trained on the new form and the P&P was updated to reference the new form. Customer care staff received updated process documentation on the new form and providers received notification on the new form and the associated process. **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	document after DHCS approval and before form is published online. ***(13. A) FW_ CE Alert _NEW_ _ Transportation PCS TAR Form Updates; B) Transportation PCS and TAR Forms)*** 14. Providers will receive notification of the new form and associated process after DHCS approval and before form is published online. ***(14. A) Provider Communication Email_TBSP12211_Email_Copy; B) Provider Communication Fax_TBSP12212_PCS_Outreach_Fax&Form(FINAL))***			
3.8.2 Treatment Authorization Request The Plan did not consistently require prior authorization for NEMT services.	**1.** In addition to the outreach, process updates, and education activities noted in 3.8.1, all Non-Emergency Medical Transportation (NEMT) services rendered by the transportation vendor are being compared to authorization system data to ensure that no services are	**2.** 3.8.2 #1 TAT call the Car **3.** 10.2.44 Non-Emergency Medical Transportation Services	**1.** Completed August 16, 2021 **2.** Completed July 14 ,2021	**07/26/21** - The following documentation supports the MCP's efforts to correct this finding: - Excel Spreadsheet, "TAT call the Car Compliance Report" as evidence that all NEMT services rendered by the transportation vendor are being

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	being rendered without a treatment authorization form for services rendered on or after 4/1/21. ***(1. 3.8.2 #1 TAT call the Car)*** 1. NEMT TAR compliance rates will be reported to UM leadership at least monthly. It will also be reported to the September Medical Services Committee (MSC), and go to committee at least annually thereafter. ***(2. 10.2.44 Non-Emergency Medical Transportation Services)***			compared to authorization system data to ensure that no services are being rendered without a treatment authorization form for services. - Updated P&P, "10.2.44: Non-Emergency Medical Transportation Services" which states that the MCP will on a quarterly basis generate a report for all NEMT request and ensure the PCS data elements are retrievable. NEMT referral report will be reported to the UM Committee per UM program. NEMT referral data is reviewed as part of the prior authorization scheduled reporting process. **11/11/21** - The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - "Medi-Cal and Cal MediConnect Physician's Certification Statement – Request for Transportation"

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				submitted by the MCP as evidence for the MCP's approved PCS form. The form was approved by DHCS on 6/15/21. The Plan has prepared a revised PCS form to combine the TAR and PCS into one. This will streamline the submission process for providers. This will also simplify the Plan's intake and authorization process in order to achieve compliance. - "Fast Track Communication (FTC) NEMT Process Updates" (11/5/21) process update by the MCP instructing on the required attachment of completed PCS forms to the case. The NEMT note is no longer required and has been removed from the process. Updated CPT code requirements based on mode of transportation. - Updated P&P, "Non-Emergency Medical Transportation Services" (12/18/21) which states the prior authorization process in the

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				MCP's system. The Intake staff creates a referral authorization in the authorization system, AuthAccel. The Request for NEMT - PCS Form is attached to the authorization record in AuthAccel (page 4). - An email, "CE Alert New Transportation PCS & TAR Form Updates" (11/08/21) which updates MCP staff that effective November 8, 2021, providers will only need to complete one form for all NEMT services. - An email and fax communication, "Redesigned Physician Certification Statement From for BlueShield of California Promise Medi-Cal and Cal MediConnect Members" (11/10/21) as evidence that the MCP has informed their network providers of their redesigned PCS form. The new design eliminates the requirement to fill out a separate Treatment Authorization Request ("TAR").

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				The Plan has updated their PCS form to combine the TAR and PCS into one which will streamline the submission process for providers and will also simplify the Plan's intake and authorization process. The Plan has sent out email and fax communication to providers informing them of the updated PCS form. The new design eliminates the requirement to fill out a separate TAR. The Plan has also updated their P&Ps to reflect quarterly monitoring for all NEMT requests. **This finding is closed.**
4. Member Rights				
4.1.1 Integration of Grievances into QI The Plan did not submit a written record of grievances and appeals at least quarterly to its Quality Assurance Committee for systematic	1. Implemented a process to submit the grievance log to the Plan's quality assurance committee, known as the Medical Services Committee (MSC). The submitted grievance log aggregate report includes the following data elements: the	**1.** A) 10.19.15 Beneficiary Grievance Management System B) Grievance Log Template	**1.** A) Completed June 30, 2021 B) Completed July 21, 2021	**07/26/21** – The following documentation supports the MCP's efforts to correct this finding: 1. A) Updated P&P, "10.19.15: Beneficiary Grievance Management System (Rev. 07/21/21). The MCP implemented a process to

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
aggregation and analysis.	total number of grievances and appeals received, the average time for resolution of grievances received, and general description of the reason for the grievance or appeal. The PHP CMO is the chair of the Plan's quarterly quality assurance committee known as the MSC and participates in the Plan's Board committee meeting, known as the BQIC. The meeting materials and information reviewed in the MSC including the grievance log are shared with the Board of Directors in the Plan's BQIC. The P&P, Beneficiary Grievance Management System (policy number 10.19.15) was updated on June 30, 2021 with the requirement for the Plan to submit the grievance and appeals log for all Medi-Cal members for quality improvement review on a quarterly basis to the Plan's			submit the grievance log to the Plan's quality assurance committee. - Updated Grievance Log Template now includes the following data elements: the total number of grievances and appeals received, the average time for resolution of grievances received, and general description of the reason for the grievance or appeal. This log is now submitted to the Plan's quality assurance committee, Medical Services committee (MSC). - The PHP CMO is the chair of the Plan's quarterly quality assurance committee known as the MSC and participates in the Plan's Board committee meeting, known as the BQIC. The meeting materials and information reviewed in the MSC including the grievance log are shared with the Board of Directors in the Plan's BQIC.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	MSC. ***(1. A) 10.19.15 Beneficiary Grievance Management System, B) Grievance Log Template)***			- The P&P, Beneficiary Grievance Management System (policy number 10.19.15) was updated on June 30, 2021 with the requirement for the Plan to submit the grievance and appeals log for all Medi-Cal members for quality improvement review on a quarterly basis to the Plan's MSC. (1. A) 10.19.15 Beneficiary Grievance Management System, B) Grievance Log Template) - Implemented a process to submit the grievance log to the Plan's quality assurance committee, known as the Medical Services Committee (MSC). - Updated a grievance log. The submitted grievance log aggregate report includes the following data elements: the total number of grievances and appeals received, the average time for resolution of grievances

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				received, and general description of the reason for the grievance or appeal. - The PHP CMO is the chair of the Plan's quarterly quality assurance committee known as the MSC and participates in the Plan's Board committee meeting, known as the BQIC. The meeting materials and information reviewed in the MSC including the grievance log are shared with the Board of Directors in the Plan's BQIC. - The P&P, Beneficiary Grievance Management System (policy number 10.19.15) was updated on June 30, 2021 with the requirement for the Plan to submit the grievance and appeals log for all Medi-Cal members for quality improvement review on a quarterly basis to the Plan's MSC. ***(1. A) 10.19.15***

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				Beneficiary Grievance Management System, B) Grievance Log Template) **This finding is closed.**
4.1.2 QOC Grievance Reviews The Plan did not refer QOC grievances to its Medical Director.	1. To ensure that the Plan categorizes grievances correctly and reports every medical grievance to the PHP CMO or Medical Director designee for review, the Plan will implement real-time clinical oversight by licensed healthcare professionals. This clinical oversight will include the review of all cases to determine the accuracy of case categorization and ensure clinical issues are appropriately identified. Feedback and corrective action will occur in real-time. This will ensure every grievance involving medical issues is submitted to the PHP CMO or Medical Director designee for review.	**1.** A) 10.19.15 Beneficiary Grievance Management System B) Blue Shield Promise_Intake Process_MHK_ AN062521 B) Blue Shield Promise_Medi-Cal Standard Grievances_M HK (003) **2.** Grievance Log Template **3.** A) 10.19.15 Beneficiary Grievance	**1.** A) Completed June 30, 2021 B) Completed August 30, 2021 **2.** Completed July 21, 2021 **3.** A) Completed June 30, 2021 B) Completed July 21,2021 C) Completed July 23, 2021 **4.** Completed August 20, 2021	**07/26/21** – The MCP submitted its Corrective Action Plan and supporting documentation. (See "Action Taken" column) The Plan lacked effective oversight to ensure proper grievances classification. - The Policy and Procedure (P&P), *Beneficiary Grievance Management System* (policy number 10.19.15) was updated on June 30, 2021 to reflect this process and DLP will be created by September 1, 2021 ***(1. A) 10.19.15 Beneficiary Grievance Management System, B) In progress)***

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	The Policy and Procedure (P&P), *Beneficiary Grievance Management System* (policy number 10.19.15) was updated on June 30, 2021 to reflect this process and DLP will be created by September 1, 2021 ***(1. A) 10.19.15 Beneficiary Grievance Management System, B) Blue Shield Promise_Intake Process_MHK_AN062521 B) Blue Shield Promise_Medi-Cal Standard Grievances_MHK (003)*** 2. PHP CMO or Medical Director designee oversight includes a monthly audit of grievance cases randomly selected from the grievance log. This monthly audit will focus on the following: • Appropriate identification of all issues and proper case categorization of non-clinical, clinical, and potential quality issues.	Management System B) Medical Director AG Case Review Meeting Materials C) AGD Org Chart **4.** Grievance Log Audit DLP_MediCal_ 082021		- PHP CMO or Medical Director designee oversight includes a monthly audit of grievance cases randomly selected from the grievance log. - The Plan has established a monthly meeting with the PHP CMO or Medical Director designee, Clinical staff and Appeals and Grievances staff to review the findings of the grievance log audit. The purpose of this meeting includes but is not limited to ensuring appropriate action has been taken such as coaching, feedback, corrective action, and ongoing process improvement. This process is outlined in the updated P&P, Beneficiary Grievance Management System (policy number 10.19.15). ***(3. A) 10.19.15 Beneficiary Grievance Management System, B) Medical Director***

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	• Appropriate resolution, including but not limited to addressing the members' specific concerns, whether clinical grievances were forwarded to PHP CMO or Medical Director designee appropriately, and whether all aspects of the grievance were resolved appropriately. ***(2. Grievance Log Template)*** 3. The Plan has established a monthly meeting with the PHP CMO or Medical Director designee, Clinical staff and Appeals and Grievances staff to review the findings of the grievance log audit. The purpose of this meeting includes but is not limited to ensuring appropriate action has been taken such as coaching, feedback, corrective action, and ongoing process improvement. This process is			***AG Case Review Meeting Materials, C) AGD Org Chart)*** **1.** A) 10.19.15 "Beneficiary Grievance Management System" **2.** Grievance Log Template **3.** A) 10.19.15 Beneficiary Grievance Management System B) Medical Director AG Case Review Meeting Materials C) AGD Org Chart **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	outlined in the updated P&P, Beneficiary Grievance Management System (policy number 10.19.15). ***(3. A) 10.19.15 Beneficiary Grievance Management System, B) Medical Director AG Case Review Meeting Materials, C) AGD Org Chart)*** 4. A Desk Level Procedure (DLP) will be created that outlines the grievance log audit steps and process. ***(4. Grievance Log Audit DLP_MediCal_082021***			
4.1.3 Resolution of Grievances The Plan did not fully resolve the members' submitted QOC grievances.	1. The Plan updated the AGD Desk Level Procedures (DLPs) that are utilized by AGD staff on how to determine member benefits, provide education to providers and members on covered services and ensure adequate case resolution. The P&P, *Beneficiary Grievance Management System* (policy number 10.19.15) has been updated documenting the above	**1.** 10.19.15 Beneficiary Grievance Management System **2.** EOC Training Deck 081821 (002), EOC Training Invite_8.23.21, EOC Training Participants_8. 23.21	**1.** Completed June 30, 2021 **2.** Completed August 23, 2021	**07/26/21** – The following documentation supports the MCP's efforts to correct this finding: Submitted documentation supports the MCP's efforts to correct this finding. Their 10.19.15 revised policy describes the requirement of AGD coordinators to identify and resolve all aspects of the grievance. Additionally, the

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	requirement that the AGD coordinators must identify and resolve all aspects of the grievance. ***(1. 10.19.15 Beneficiary Grievance Management System)*** 2. All AGD staff will be notified and retrained on the updated DLPs. ***(2. EOC Training Deck 081821 (002), EOC Training Invite_8.23.21, EOC Training Participants_8.23.21)***			Policy also requires monthly audits, the analysis of case classification (both clinical and non-clinical) and Potential Quality Issues, and appropriate resolution of all member concerns. Training materials addressed Essential Health Benefits, Medi-Cal Evidence of Coverage (EOC), and how to locate EOC. Training materials also addressed how to successfully identify and respond to a QOC grievance and ensure all aspects of the grievance are addressed and clearly documented. Lastly, the updated Grievance Coordinator Process demonstrates that a review of the case details will ensure all aspects of the member's requests are being addressed. Supporting Documentation: • Updated P&P, "10.19.15: Beneficiary Grievance Management System (Rev. 08/10/21)

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				• Power Point Training, "Medi-Cal Benefits/Appeals & Grievances" (08/23/21) and list of attendees. • Power Point Training, "Quality of Service and Timely Resolution of Grievances Involving Clinical Issues" (08/12/21) and list of attendees. • Trainings addressed the following: Medi-Cal benefits, Evidence of Coverage, education for both members and providers on covered benefits. • Grievance and Appeals training included the following: Identifying and responding to quality of care grievances, ensuring all aspects of grievances are addressed/documented, that clinical matters are to be referred to the Medical

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				Director, Definitions of QOS and QOC grievances, Audit findings, Timely resolution of clinical issues and clinical oversight is provided on all grievance cases. These trainings address issues identified in the audit verification studies, including covered benefits, timely resolution requirements and resolution of all aspects of a member's grievance. **This finding is closed.**
4.1.4 Timely Resolution of Grievances Involving Clinical Issues The Plan's Grievance Coordinators did not immediately refer all QOC grievances to the Plan's Medical Director for resolution	***1.*** The Plan updated the P&P, *Beneficiary Grievance Management System* (policy number 10.19.15) to include that the AGD coordinators must resolve all aspects of the grievances. If a case includes both a Potential Quality Issue (PQI) and QOC grievance, the PQI will	**1.** 10.19.15 Beneficiary Grievance Management System **2.** Clinical_Oversight_PQI_Training_8.12, 2. Clinical oversight	**1.** Completed June 30, 2021 **2.** Completed August 12, 2021 **3.** A) Completed June 21, 2021 B) Completed August 30, 2021	**07/26/21** – The MCP submitted its Corrective Action Plan and supporting documentation. (See "Action Taken" column) Submitted documentation supports the MCP's efforts to correct this finding. • The Plan updated the P&P, Beneficiary

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
within the contractual timeframe.	be forwarded to the Clinical Quality Review team (CQR) and the QOC grievance will be resolved in the Appeals and Grievance department. ***(1. 10.19.15 Beneficiary Grievance Management System)*** ***2.*** All AGD staff will be notified and retrained on the updated P&P. ***(2. Clinical_Oversight_PQI_Training_8.12, 2. Clinical oversight training meeting attendees 8.12, 2. Clinical oversight training meeting invite 8.12)*** 3. To ensure that the Plan categorizes grievances correctly and reports every medical grievance to the PHP CMO or Medical Director designee for review, the Plan will implement real-time clinical oversight by licensed healthcare professionals. This clinical oversight will	training meeting attendees 8.12, 2. Clinical oversight training meeting invite 8.12 **3.** A) 10.19.15 Beneficiary Grievance Management System B) Blue Shield Promise_Intake Process_MHK_AN062521, 3. B) Blue Shield Promise_Medi-Cal Standard Grievances_MHK (003) **4.** Grievance Log Template **5.** A) 10.19.15	**4.** Completed July 21, 2021 **5.** A) Completed June 30, 2021 B) Completed July 21, 2021 C) Completed July 23, 2021 **6.** Completed August 20, 2021	Grievance Management System (policy number 10.19.15) to include that the AGD coordinators must resolve all aspects of the grievances. If a case includes both a Potential Quality Issue (PQI) and QOC grievance, the PQI will be forwarded to the Clinical Quality Review team (CQR) and the QOC grievance will be resolved in the Appeals and Grievance department. The CQR team will advise if only a PQI exists or whether there is a QOC grievance that requires separate resolution within 30 calendar days. • Per their revised policy, the CMO and/or Medical Director will work closely with the Appeals & Grievance (AG) RN Manager to ensure that member grievances

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	include the review of all cases to determine the accuracy of case categorization and ensure clinical issues are appropriately identified. Feedback and corrective action will occur in real-time. This will ensure every grievance involving medical issues is submitted to the PHP CMO or Medical Director designee for review. The Policy and Procedure (P&P), *Beneficiary Grievance Management System* (policy number 10.19.15) was updated on June 30, 2021 to reflect this process and DLP will be created by September 1, 2021. ***(3. A) 10.19.15 Beneficiary Grievance Management System, B) Blue Shield Promise_Intake Process_MHK_AN062521, 3. B) Blue Shield Promise_Medi-Cal Standard***	Beneficiary Grievance Management System B) Medical Director AG Case Review Meeting Materials C) AGD Org Chart **6.** Grievance Log Audit DLP_MediCal_082021		involving clinical issues are properly classified & reviewed by qualified medical personnel. The grievance coordinator will consult with the AG RN/LVN to ensure all aspects of the grievances are resolved. The Plan's Medical Director has delegated responsibility to the Plan's Appeals and Grievances Registered Nurse Manager to ensure that member grievances involving clinical issues are properly classified and reviewed by qualified medical personnel. • All AGD staff was notified and retrained on the updated P&P. Training materials addressed the ability to successfully identify and respond to a QOC grievance and ensure all aspects of the grievance were addressed and correctly documented. In addition,

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	Grievances_MHK (003)) 4. PHP CMO or Medical Director designee oversight includes a monthly audit of grievance cases randomly selected from the grievance log. This monthly audit will focus on the following: • Appropriate identification of all issues and proper case categorization of non-clinical, clinical, and potential quality issues. • Appropriate resolution, including but not limited to addressing the members' specific concerns, whether clinical grievances were forwarded to the PHP CMO or Medical Director designee appropriately, and whether all aspects of the grievance were			trainings demonstrate grievances pertaining to clinical matters are referred to the Medical Director. • The MCP's Grievance Log captures the total number of grievance and appeals received, the average time for resolution of grievances received, and general description of the reason for the grievance. • A monthly audit of the grievance log and will allow comprehensive discussion of all grievances. • Their updated desktop procedure outlines the steps in the process for completing the audit of grievances documented in the Grievance Log. • Supporting Documentation: • Updated P&P, "10.19.15: Beneficiary Grievance

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	resolved appropriately. ***(4. Grievance Log Template)*** 5. The Plan has established a monthly meeting with the Medical Director, Clinical staff and Appeals and Grievances staff to review the findings of the sample audit of grievance log audit. The purpose of this meeting is to provide oversight of the grievance function, including but not limited to includes but is not limited to ensuring appropriate action has been taken such as coaching, feedback, corrective action, and ongoing process improvement. ***(5. A) 10.19.15 Beneficiary Grievance Management System, B) Medical Director AG Case Review Meeting Materials, C) AGD Org Chart)*** 6. A Desk Level Procedure (DLP) will be created that outlines the grievance log audit steps and process. ***(6.***			Management System (Rev. 08/10/21) • Power Point Training, "Quality of Service and Timely Resolution of Grievances Involving Clinical Issues" (08/12/21) and list of attendees. • Log, "Grievance Log Template" (07/2021). • Medical Director AG Case Review Meeting Materials (07/21/21) • AGD Org Chart, (07/2021) • Desk Level Procedure, "Grievance Log Audit Steps" **This finding is closed.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	Grievance Log Audit DLP_MediCal_082021)			
4.2.1 Linguistic Services The Plan did not provide its members with translated Grievance Acknowledgement and Resolution letter enclosures in their threshold languages.	1. The Plan updated the Medi-Cal Translation DLP to include that the enclosures need to be sent in the correct threshold language. ***(1. Blue Shield Promise MHK Translation Process)*** 2. The Plan provided additional training by communicating the translation process and requirements to the staff to ensure the enclosures are in the correct threshold language. ***(2. Staff Communication Email)*** 3. The internal AGD Quality Team has incorporated auditing the enclosures to ensure they are being sent in the correct threshold language along with the acknowledgement and resolution letters. ***(3. Quality Team Email Communication)***	**1.** Blue Shield Promise MHK Translation Process **2.** Staff Communication Email **3.** Quality Team Email Communication **4.** Blue Shield Promise_Translation Process_MHK **5.** Inventory Monitoring Log	**1.** Updated April 13, 2021 and revised July 18, 2021 **2.** Completed February 12, 2021 **3.** Completed March 18, 2021 **4.** Completed August 30, 2021 **5.** Completed May 1, 2021	**7/26/21** - The following documentation supports the MCP's efforts to correct this finding: 1. Updated Medi-Cal Translation DLP 2. Email communication to staff dated 2/12/21 instructs staff to ensure translated enclosures are included with acknowledgment and resolution letters. **3.** AGD Quality Team Email Communication instructing to audit translation of enclosures. **4.** Example monitoring log template.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	4. In addition, the AGD Quality Team will perform monthly focused audits on all cases where members have a threshold language other than English to ensure all letters and enclosures are being translated in the threshold languages. The translation DLP will be updated to add a section outlining the Quality Team's focused audit process. ***(4. Blue Shield Promise_Translation Process_MHK)*** 5. The Plan has created a report to proactively identify and monitor open inventory that requires translations in real-time to ensure translations are not missed. This report is checked daily by the translation coordinator to ensure all translations are being completed as required. ***(5. Inventory Monitoring Log)***			**8/31/21** - The following additional documentation supports the MCP's efforts to correct this finding: Translation Process MHK updated to include focused audit process. **9/15/21** - The following additional documentation supports the MCP's efforts to correct this finding: - Focused audit results for June and July 2021. - Example of Inventory Monitoring Log demonstrated log is currently being used. The MCP updated its translation process to include the need for sending translated enclosures. Training was provided to staff to ensure enclosures are translated into the correct threshold language. MCP uses a log to monitor open inventory to ensure translations are not

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				missed. MCP conducts internal audits to verify that required translations are taking place. Examples from June and July 2021 were provided. The MCP has demonstrated they have a process in place to monitor the translation of member grievance acknowledgement and resolution letters and their enclosures. **This finding is closed.**
5. Quality Management				
5.2.1 New Provider Training The Plan did not ensure subcontractors trained new providers within the contractual timeframe.	1. New process developed requiring delegated groups to provide their new provider rosters with indication of the providers training date. If no training date provided, the provider will not be loaded and made active in the network. ***(1. Medi-Cal Orientation Training Attestation Date)*** 2. System enhancement made to the provider database (PIMS) to capture and track	**1.** Medi-Cal Orientation Training Attestation Date **2.** Medi-Cal Orientation Training Attestation Date **3.** 10.30.4 Oversight of Delegated	**1.** Completed July 7, 2021 Process go live will be September 1, 2021 **2.** Completed July 7, 2021 Process go live will be September 1, 2021 **3.** Completed July 20,2021	**07/26/21** - The following documentation supports the MCP's efforts to correct this finding: - Operating Procedure document, "Medi-Cal Orientation Training Attestation Date" (07/07/21) which explains the MCP's new process requiring delegated groups to provide their new provider rosters with indication of the providers training date. If no training date was provided, the provider will

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	provider training dates. ***(2. Medi-Cal Orientation Training Attestation Date)*** 3. Oversight of provider training will continue on an annual basis. This includes review of delegate policies and procedures, quarterly new provider listing reviews and reviews of training attestations***. (3. 10.30.4 Oversight of Delegated Entity's Contracted Provider Orientation and Education)*** 4. Monitoring of newly implemented process – initial quality check includes the assessment of three months following process go-live date to ensure providers are not being made active unless verification of the training date has been provided on the delegate's rosters. A report will be pulled from PIMS including all newly added Medi-Cal providers	Entity's Contracted Provider Orientation and Education **4.** A.) DHCS Audit – Provider Training CAP Memo B.) Exhibit A - Baseline Monitoring Report, C.) Exhibit B - Provider Operations Training Session Agenda and Mting Invite D.) Exhibit C - Monitoring Report After Reconciliation E.) Exhibit D -	**4.** Completed November 30,2021 **5.** Completed July 2,2021 **6.** Completed August 25, 2021	not be loaded and made active in the network. - Updated P&P, "10.30.4: Oversight of Delegated Entity's Contracted Provider Orientation and Education (New and Ongoing)" (07/20/21) as evidence that oversight of provider training will continue on an annual basis. This includes review of delegate policies and procedures, quarterly new provider listing reviews, and reviews of training attestations. - "Medi-Cal New Provider Orientation Notice to Delegate" (07/01/21) as evidence that the MCP is sending communication by letter to the delegate provider to reinforce requirements and the MCP's process. The notice letter is a reminder to the delegated provider that they are required to ensure that all newly contracted providers receive provider training within ten (10) business days of becoming a participating Medi-Cal provider

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	within the three months prior to pulling the report. The report will be compared to the quarterly new provider listings from the delegated entities. Any discrepancies will be addressed as a corrective action with the delegate. Ongoing monitoring will continue on a quarterly basis. ***(4. A.) DHCS Audit – Provider Training CAP Memo, B.) Exhibit A - Baseline Monitoring Report, C.) Exhibit B - Provider Operations Training Session Agenda and Mting Invite, D.) Exhibit C - Monitoring Report After Reconciliation*** 5. Delegate Provider communication sent to reinforce requirements and Plan process. ***(5. Medi-Cal New Provider Orientation Notice to Delegate)*** 6. Internal Provider Operations staff training on new	X IPA Termination Notice F.) Exhibit E – X IPA LLC CAP **5.** Medi-Cal New Provider Orientation Notice to Delegate **6.** Medi-Cal Orientation Training Attestation date - Processor roll out		with their medical group and/or specialty plan. **09/08/21** - The following additional documentation supports the MCP's efforts to correct this finding: - Meeting Invitation, "Medi-Cal Orientation Training Attestation Date – Processor Roll Out" as evidence that MCP staff received training on 8/25/2021 on the MCP's new process requiring delegated groups to provide their new provider rosters with indication of the providers training date. **01/06/22** - The following additional documentation supports the MCP's efforts to correct this finding: - Spreadsheet samples, "Baseline Monitoring Report" and "Monitoring Report After Reconciliation" (November 2021) as evidence that the MCP has implemented their new

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	process conducted. ***(6. Medi-Cal Orientation Training Attestation date - Processor roll out)***			monitoring process. The report includes a column to track the "Medi-Cal Orientation Completion Date." - "Notice of Termination" (June 2021) letter sent to the delegated entity as evidence that the MCP has terminated providers who are out of compliance. - "Corrective Action Plan" (November 2021) as evidence that the MCP has placed one of their delegated entities under a CAP to be in compliance. The delegate has completed their CAP activities with evidence pending for the MCP to validate. **This finding is closed.**

Submitted by: Yasamin Hafid [Signature on file] Date: July 26, 2021
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