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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

October 4, 2017

Michael Schrader, CEO
CalOptima
505 City Parkway West
Orange, CA 92868

RE: Department of Managed Health Care Cal MediConnect Survey

Dear Mr. Schrader:

The Department of Managed Health Care conducted an on-site Cal MediConnect Survey of CalOptima, a Medicare-Medicaid Plan (MMP), from February 6, 2017 through February 10, 2017. The survey covered the period of July 1, 2015 through October 31, 2016.

On September 29, 2017, the MMP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on July 5, 2017.

All items have been reviewed and found to be in compliance. The CAP is hereby closed. The enclosed report will serve as DHCS' final response to the MMP'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) 552-8946 or Joshua Hunter at (916) 440-7587.

Sincerely,

Jeanette Fong, Chief
Compliance Unit

Enclosures: Attachment A CAP Response Form

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

ATTACHMENT A
Corrective Action Plan Response Form

Plan Name: CalOptima

Survey Type: DMHC Cal MediConnect Medical Survey **Review Period: 7/1/15 – 10/31/16**

MMPs 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. MMPs are required to submit the CAP via email in word format which will reduce turnaround time for DHCS to complete its review.

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

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

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
1. Utilization Management				
#1: The Plan does not adequately demonstrate that it systemically and routinely analyzes utilization management data to monitor for potential under- and over-utilization of Cal MediConnect services.	In its report, the DMHC noted that the Plan "stated that while data was collected during the survey period, the *Over Under Utilization Matrix* was not implemented until January 2017." (Page 9) and that "the Plan presented no evidence of effective tracking, trending, and analysis of utilization data…to monitor for, and address, under- and over-utilization." (Page 10). The implementation of the Over-Under Utilization Matrix is a key element of the Plan's strategy to systematically and routinely analyze utilization management data to monitor for potential under- and over-utilization of Cal MediConnect services. The Plan acknowledges that it could not provide evidence of implementation of the Over-Under Utilization Matrix at the time of DMHC's survey. The Plan can now demonstrate evidence that it is performing these functions in accordance with its written Policy & Procedure GG.1532: Over and Under Utilization Monitoring [*previously submitted and reviewed during the survey*] and the requirements of	• 1_UMC Agenda_05.25.17 • 1_2017 Utilization Work Plan and Evaluation • 1_Q1 2017 Over-Under Utilization Matrix_OCC	Completed May 25, 2017, and will be continued on a quarterly basis in perpetuity	**08/07/17** - The following documentation supports the MMP's efforts to correct this finding: - 2017 Utilization Work Plan and Evaluation which includes a summary table of all Q1 2017 activity related to over/under-utilization. The table includes a discussion of various metrics and results as well as next steps (pages 4-8). - UM Committee meeting agenda (05/25/17) which serves as evidence that the MMP reviewed 2017 UM Work Plan and Evaluation.

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	the 3-way Cal MediConnect Contract, as remediation of this identified deficiency. The second quarter (Q2) 2017 meeting [Attachment: 1_UMC Agenda_05.25.17] of the Plan's Utilization Management Committee (UMC) was held on May 25, 2017. During this meeting, the UMC reviewed the quarterly updates to the Plan's Utilization Management (UM) Work Plan and Evaluation [Attachment: 1_2017 Utilization Work Plan and Evaluation], which was updated to include the Over-Under Utilization Matrix [Attachment: 1_2017 Over-Under Utilization Matrix_OCC], reflective of data collected in Q1 2017. The matrix is a mechanism to track over- and under-utilization measures across the Plan and its delegated health networks. Since the matrix was implemented in Q1 2017, the Plan has been continually assessing the collected data and reviewing industry standard benchmarks in the development of Plan-specific benchmarks to incorporate into the matrix. Especially when performing cross-network comparisons and comparisons to established benchmarks—which the matrix allows for—Plan staff and the Plan's UMC is responsible for monitoring and detecting patterns, trends, and outliers, and acting accordingly. At the time of this writing, the Plan is collecting Q2 2017 data to be presented in Q3 2017 to the Plan's UMC. At that time, the Plan's discussion will include 2 quarters of data and will allow the UMC the opportunity to compare historical data and begin to observe trends. As time progresses, the process is anticipated to grow to be more robust as the Plan refines benchmarks and data collection efforts over time.			- Over-Under Utilization Matrix (Q1 2017) as evidence that MMP is collecting various utilization data (e.g., inpatient measures, authorization data, G&A overturn rates, HEDIS measures, etc.) for each of its delegated entities. - 2016 Utilization Management Program Evaluation (approved 02/23/17) as evidence that MMP now has a more enhanced system for tracking and trending over/under utilization and that this focus will continue in 2017. - Member and Provider Trend Reports 1Q, 2017 (05/23/17) as evidence that MMP is tracking appeal overturn rates and reasons for each of its delegate health networks. **This finding is closed.**
2. Continuity of Care				
#2: The Plan does not consistently develop an Individualized Care Plan for enrollees within 30 working days of Health Risk Assessment completion.	The Plan respectfully requests DHCS's and DMHC's reconsideration of potential deficiency #2. <u>Basis for Reconsideration Request</u> The Plan notes that it has developed and strictly followed a rigorous process regarding the development of Individualized Care Plans (ICPs) for Cal MediConnect enrollees that was in place during the audit period, and that was developed in accordance with the Plan's understanding of the requirements identified in the 3-way Cal MediConnect contract and further described and referenced in DHCS Duals Plan Letter 15-001 and the DMHC Technical Assistance Guide for Continuity of Care related to Cal MediConnect	• *File #3_OCC_ICP,File #4_OCC_ICP, File #5_OCC_ICP, File #9_OCC_ICP, File #11_OCC_ICP, File #17_OCC_ICP, File #18_OCC_ICP, File #23_OCC_ICP, File #24_OCC_ICP, File #25_OCC_ICP, File #28_OCC_ICP, File #32_OCC_ICP, File #33_OCC_ICP, File #36_OCC_ICP, File #37_OCC_ICP, File #38_OCC_ICP, File #41_OCC_ICP, File #43_OCC_ICP, File #49_OCC_ICP, File #53_OCC_ICP, File #54_OCC_ICP, File #58_OCC_ICP, File #61_OCC_ICP, File #66_OCC_ICP, File #67_OCC_ICP, File #70_OCC_ICP, File*	If necessary, within 60 days of DHCS' acceptance of Plan's CAP response	**08/28/17** - The following documentation supports the MMP's efforts to correct this finding: -DHCS provided technical assistance to the MMP (written correspondences 08/16/17 – 08/28/17) clarifying the requirement to develop and *complete* the ICP within 30 working days of HRA completion. **09/29/17** - The following documentation supports the MMP's

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	Surveys. The Plan notes that the requirements described in these documents are as follows (the Plan's emphasis): • Orange County Health Authority Cal MediConnect Three-Way Contract §2.8.3.1: ICPs will be **developed** within thirty (30) working days of HRA completion. • DHCS Duals Plan Letter 15-001 (Page 2): Should a dual-eligible beneficiary demonstrate the need for a Care Plan, MMPs are required to **develop** a plan and engage the dual-eligible beneficiary and/or his or her representative(s) in its design. • DMHC TAG Tool, Continuity of Care, Cal MediConnect Survey, CC-002 – Key Element 3, Assessment Question 3.1: When the need for an ICP is demonstrated, does the Plan ensure that an ICP is **developed** for each Cal MediConnect Enrollee within 30 working days of Health Risk Assessment (HRA) completion? All guidance available to the Plan indicates that the requirement of the Plan is to **develop** an ICP within 30 days of HRA completion. In 26 of the 27 files that DMHC identified as deficient in its report, and indeed in 69 of the 70 total reviewed files—or 98%—the Plan successfully **developed** an ICP within 30 days of the HRA completion date. The files that DMHC identified as deficient are submitted as attachments to this narrative and presented as evidence, with updated Plan annotation and bookmarks identifying the ICP **development** date [Multiple Attachments, such as "*File #XX_OCC_ICP*". Additionally, a summary of the findings based on review of these files is also attached [Attachment: 2_CoC File Assessment]. The Plan respectfully notes that DMHC's report (Page 11) appears to indicate a different standard than is described in the contract, stating [the Plan's emphasis] that "The Orange County Health Authority Cal MediConnect Three-Way contract §2.8.3.1 requires that an ICP be **completed** for each enrollee within 30 working days of HRA completion." The Plan notes that the contract language, as	*#72_OCC_ICP.* • 2_CoC File Assessment • 2_DMHC File Review Log Requirements		efforts to correct this finding: -Draft P&P #CMC.6041, "Individual Care Plan (ICP): Monitoring and Timeliness," which was submitted to DHCS for review and approval and reviewed internally by the MMP's PRC (09/27/17). The P&P outlines the MMP's processes for ensuring development and completion of the ICP within 30 working days of HRA completion (consistent with the contractual requirement) as well as delineates activities for monitoring for timely completion. MMP's licensed case managers are tasked with reviewing each finalized ICP for quality and timeliness. On 10/02/17, DHCS provided MMP with approval of the P&P and recommended continuing all outlined monitoring activities outlined to ensure adherence to the required timeframe for ICP completion. **This finding is closed.**

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	quoted above, requires that the ICP be **developed** within 30 days, not completed. The DMHC's pre-onsite document request also requested that the Plan complete file submissions that included a field that identified the "Date of **completion** of Interdisciplinary Care Plan" [Attachment: 2_DMHC File Review Log Requirements, Page 10], which the Plan understood and submitted as the Individualized Care Plan **completion** date, but hereby notes that this differs from the Individualized Care Plan **development** date. The Plan notes that an enrollees' care needs change over time and are identified as a product of interactions with the Plan and various health care professionals, so an ICP can and does change over time as well. While the Plan recognizes this and requests the participation of those involved in a given enrollee's care, it also notes that an enrollee's Primary Care Physician (PCP) may choose to not sign off on that enrollee's ICP until after a visit with the enrollee, for example. While that signature remains outstanding according to the PCP's prerogative in this example, it does not mean that the ICP has not been developed. The development of the ICP is the Plan responsibility outlined in the contract, and the Plan believes the attached evidence indicates that the Plan meets its responsibility in this regard. The Plan would also like to call to DHCS's and DMHC's attention that it rigorously monitors and ensures that ICPs are indeed being **developed** within 30 days of HRA completion, and has done so since the inception of the Plan's Cal MediConnect program. The Plan's systematic monitoring includes the manual audit of 100% of HRAs and ICPs by Registered Nurses. Each file is audited at two intervals: first at the time of HRA collection, ICP development, and assignment of case management level, and later upon ICP completion. Timeliness is monitored and reported monthly internally to the Plan's Quality Improvement Committee and the Audit and Oversight Committee, a subcommittee of the Plan's Compliance Committee. Subsequently, these results are presented to the Compliance Committee on a quarterly basis. The results are also reported monthly externally to the Plan's delegated health networks, who are subject to financial penalties in the event that audit results fall below 80% for two consecutive months. Timeliness and quality of ICPs are indeed the key elements of the established audit criteria. <u>Proposed CAP Efforts and Associated Concerns</u>			

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	If it is the interpretation of DHCS and DMHC that the Orange County Health Authority Cal MediConnect Three-Way Contract §2.8.3.1 requires Plans to not only develop, but fully complete an ICP within thirty working days of HRA completion, the Plan respectfully requests clarifying language to that effect in the referenced contract or in sub-regulatory guidance. In such an instance and if the DHCS and DMHC do not agree with the Plan's request for reconsideration, the Plan's proposed corrective action is to clarify in its documents and processes that ICPs shall be **completed** within thirty working days of HRA completion, and not **developed** within thirty working days. Resulting changes to documents would include, but not be limited to, revisions to the Plan's Policy & Procedure CMC.6031: Health Risk Assessment [*previously submitted as a Pre-Onsite Survey review document to DMHC*] to note this change in the requirement and to define completion of an ICP. The Plan defines completion of an ICP as the development of an ICP for Basic Case Management enrollee and as either the date the Interdisciplinary Care Team (ICT) meets and/or the enrollee's assigned Case Manager signs the ICP for Complex Case Management enrollees and Care Coordination enrollees. In the event that these changes are made to the Plan's documents they would not only be communicated to the Plan's delegated health networks, but the networks would receive additional training to educate them on the updated requirements. The Plan would also incorporate the monitoring of this standard into its existing efforts, which comprise the 100% audit of HRAs and ICPs. The Plan proposes that, in the event DHCS and DMHC do not agree with the Plan's request for reconsideration, it will take the above steps within sixty (60) days of DHCS' acceptance of the Plan's CAP response. In light of this, the Plan respectfully requests to continue its existing process, which consistently ensures ICP **development** within thirty working days of HRA completion, encourages meaningful review of and feedback regarding the ICP, and is supported by a comprehensive monitoring structure. However, based on DHCS's and DMHC's feedback and response to this request, the Plan is prepared to modify its processes as described above to meet DHCS's and DMHC's expectations and ensure ICP **completion** within thirty working days of HRA completion.			

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	8/24/17 - Follow-up The Plan thanks the Department for its additional feedback as a result of the Plan's August 7th CMC CAP submission. For the Department's consideration, the Plan respectfully submits a revised description of a *completed* ICP (Attachment: 2_CMC.6031: Health Risk Assessment_Proposed Draft). For a Basic Case Management enrollee, section III.E.2.i.1-2 of CalOptima policy CMC.6031 (Attachment: 2_CMC.6031: Health Risk Assessment_Proposed Draft), notes that for a member who has *not requested* an ICT the "ICP will be considered complete when the member has an opportunity to review and sign the care plan. This date shall be calculated as 5 days after the date the care plan and interventions are mailed to the member." " For a Basic Case Management enrollee who *requests an ICT*, CMC.6031 notes that "the care plan will be considered complete after the Interdisciplinary Care Team (ICT) meets; on the date the member's assigned Case Manager signs the ICP." CMC.6031 also addresses those members with a higher risk; those who receive Complex Case Management or Care Coordination Case Management. Section III.E.3 of CMC.6031 states that the care plan will be created within 30 days of the collection of the HRA and will be considered *complete* "after the Interdisciplinary Care Team (ICT) meets; on the date the member's assigned Case Manager signs the ICP." In anticipation of the Department's review, the Plan continues to work diligently to assess and ensure impacted processes are also updated. Following the Department's review and approval of the revised definitions, the Plan is prepared to take the following actions: • Finalizing the draft updates to Policy CMC.6031 in order to formally adopt the updated definition of when an ICP is considered complete; • Develop a new policy describing the process for monitoring quality and timeliness of ICPs; and Additional Training and Education (Delegates): Following the approval of the outlined process and definitions, CalOptima intend to	**8/24/17 – Follow-up** • 2_CMC.6031: Health Risk Assessment_Proposed Draft	**9/29/17 - Follow-up** Within 60 days of DHCS' acceptance of Plan's CAP response.	

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	train and educate its delegated health networks on any revised processes which impact them. **9/29/17 - Follow-up** In follow-up to the Plan's 8/24/17 submission, the Plan respectfully submits CalOptima policy CMC.6041: Individual Care Plan (ICP): Monitoring and Timeliness [Attachment: 2_CMC.6041_PRC 20170926], for DHCS review and approval. CMC.6041 defines the process for creation and completion of an Individual Care Plan (ICP) for Members enrolled in OneCare Connect (OCC), as well as the process for monitoring timeliness and quality of the ICPs. CMC.6041 was recently approved by CalOptima's Policy Review Committee on 9/27/17. CalOptima respectfully request DHCS review and approval of CMC.6041 by 11/1/17. Following DHCS review and approval, CalOptima intends to communicate this policy to its impacted delegated health networks and allow them 30 calendar days to update/revise any processes which impact them. As originally communicated, CalOptima intends to effectuate CMC.6041 within 60 calendar days of DHCS' acceptance of this CAP submission.	**9/29/17 - Follow-up** 2_CMC.6041_PRC 20170926		
3. Availability and Accessibility				
#3: The Plan's policies and procedures fail to require flexibility in scheduling to accommodate the needs of enrollees with disabilities.	The Plan updated policy MA.7007: Access and Availability by adding language to section II.D [Attachment: 3_MA.7007 Access and Availability Policy] to incorporate additional language in response to identified finding. These changes were approved by the Plan's internal Policy Review Committee (PRC) on July 26, 2017, and will be finalized by the Plan's Chief Executive Officer following DHCS review and approval of the changes. As an additional measure to ensure that Providers heed the requirement, the Plan has also incorporated a related question into its annual Timely Access Survey Tool. The Plan revised its annual Timely Access Survey tool [Attachment: 3_2017 Timely Access Survey Tool], as evidenced on page 3. This year's survey is expected to be fielded in August 2017.	• 3_MA.7007 Access and Availability Policy • 3_2017 Timely Access Survey Tool	August 1, 2017 August 2017	**08/07/17** - The following documentation supports the MMP's efforts to correct this finding: - P&P MA.7007 Access and Availability (08/01/17) was updated to require providers to offer flexibility in scheduling to accommodate the needs of Members with disabilities (page 1). - 2017 Timely Access Survey Tool was updated to include a question asking providers if they offer flexibility in scheduling to accommodate the needs of Members with disabilities in order to monitor providers' compliance with this requirement. **This finding is closed.**

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#4: The Plan failed to demonstrate that it takes into consideration the anticipated number of Cal MediConnect enrollees when evaluating adequate access to Medicaid-based services.	On an annual basis, the Plan has historically calculated projected Cal MediConnect enrollment. However, the Plan did not identify in P&P how these projected enrollment figures were to be used for purposes of evaluating adequate access to Medicaid-based services in Cal MediConnect. To this end, the Plan updated policy MA.7007: Access and Availability, section II.I.9.e. [Attachment: 4_MA.7007 Access and Availability Policy] to incorporate additional language in response to identified finding. These changes were approved by the Plan's internal Policy Review Committee (PRC) on July 26, 2017, and will be finalized by the Plan's Chief Executive Officer following DHCS review and approval of the changes. Projected Cal MediConnect enrollment calculations are made corresponding to the Plan's fiscal-year, and are based on a combination of historic trends and prospective sales forecasts. Historic enrollment from program inception through current is segregated by Plan network and delegation type (i.e. directly contracted providers, Health Maintenance Organization contracts, Physician Hospital Consortia contracts, and Shared Risk Group contracts) and population cohort, as identified by DHCS. Enrollment and disenrollment trends and rates of growth for each segment are then analyzed. Prospective trends are then based on a blend of linear regression and rolling averages of actual experience. In addition, information from the Plan's Cal MediConnect Sales & Marketing team was used to supplement the historic trend data. The number of sales staff, historic sales trends, and prospective sales targets are also taken into account. Projections for each population segment are then aggregated to create a consolidated enrollment forecast for the Cal MediConnect line of business. Additionally and in concert with the changes to Plan P&Ps, an availability report was generated to monitor network adequacy that takes into consideration the anticipated number of OneCare Connect members [Attachment: 4_Availability Report_Anticipated Membership_20170701]. The report includes provider to member ratio utilizing provider data as of July 1, 2017 and the anticipated number of enrollees for Cal MediConnect for FY 2017-18. This report will be generated annually at the beginning of the fiscal year,	• 4_MA.7007 Access and Availability Policy • 4_Availability Report_Anticipated Membership_20170701	August 1, 2017 July 28, 2017	**08/07/17** - The following documentation supports the MMP's efforts to correct this finding: - P&P MA.7007 Access and Availability (08/01/17) was updated to include language regarding taking into consideration the anticipated Member enrollment numbers when evaluating adequate access to Covered Services. - Anticipated Membership Report (07/01/17) is used monitor network adequacy. It takes into consideration the number of anticipated OneCare Connect members. The report will be generated at the beginning of each fiscal year. **This finding is closed.**

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	and as necessary.			
4. Members' Rights				
#5: The Plan failed to include the date of receipt of standard grievances in its acknowledgment letters. In addition, the Plan's grievance acknowledgment and resolution letters do not display the required information in 12-point, bold-faced font.	The Plan respectfully requests DHCS's and DMHC's reconsideration of potential deficiency #5. The Plan respectfully submits a detailed file review and response in Attachment: 5_CalOptima_Request for Reconsideration - DMHC CMC Survey. As a summary of the information contained in this document, the Plan notes that in all instances identified as deficient, the Plan accurately and correctly followed CMS-/DHCS-approved template documents. When the templates called for dates to be included in the acknowledgement letters, they were included. As a County Organized Health Systems (COHS) Medi-Cal Managed Care Plan created pursuant to California Welfare and Institutions Code section 14087.54, the Plan is not legally required to be Knox-Keene licensed and does not hold a Knox-Keene License for its Medi-Cal line of business. As such, the Plan's Cal MediConnect enrollees do not have access to the DMHC Help Center or the Independent Medical Review (IMR) process with respect to Medicaid-based services. As such, the Plan is not required to include all of the language identified in Section 1368.02(b), including the Department's telephone number, TDD/TTY line, and internet website in its approved template documents. **8/24/17 – Follow-up** • Based on DHCS feedback, the Plan respectfully submits its revised Appeal acknowledgment letters (Attachments: 5_ Appeal Acknowledgement Letter Template_Verbal Request for Appeal **and** 5_Appeal Acknowledgement Letter Template_Not Met Expedite) which include the requested *appeal receipt date*. The Plan uploaded these templates for CMS/DHCS review and approval via the Health Plan Management System (HPMS) portal on August 24, 2017 (Attachment: 5_HPMS Verification of Upload). The Plan anticipates a 45 calendar day (est. approval: 10/09/17) review period and as such expects to implement the change no later than 10/16/17*; this date will allow sufficient time to train staff and operationalize the revised letters.	• 5_ CalOptima_Request for Reconsideration - DMHC CMC Survey • 5_Appeal Acknowledgement Letter Template_Not Met Expedited • 5_Appeal Acknowledgement Letter Template_Verbal Request for Appeal • 5_CMS and DHCS Approval_Appeal Acknowledgement Letter Template_Not Met Expedited • 5_CMS and DHCS Approval_Appeal Acknowledgement Letter Template_Verbal Request for Appeal • 5_CMS and DHCS Approval_Grievance Acknowledgement Letter • 5_Grievance Acknowledgement Letter Template • 5_File 30_Grievance Acknowledgement Letter • 5_File 32_Grievance Acknowledgement Letter **8/24/17 – Follow-up** • 5_ Appeal Acknowledgement Letter Template_Verbal Request for Appeal • 5_Appeal Acknowledgement Letter Template_Not Met Expedited • 5_HPMS Verification of Upload	October 16, 2017	**08/16/17** - The following documentation supports the MMP's efforts to correct this finding: - Written correspondence between DHCS and the MMP (08/16/17-08/17/17) clarified that the MMP has been using notices that had been approved for use by CMS. The grievance/appeal receipt date was missing from the *appeal* acknowledgment letters only and not *grievance* acknowledgment letters. As such, this finding was limited to only *appeal* acknowledgment letters not containing the appeal receipt date. MMP submitted additional supporting documentation indicating that all *grievance* files review were compliant. **08/24/17** - The following documentation supports the MMP's efforts to correct this finding: - Draft appeal acknowledgment template letters as evidence that MMP has inserted into its template the receipt date of the appeal. - Email notification from MMP to CMS (08/24/17) as evidence that MMP has submitted draft appeal acknowledgment letters to CMS for approval. Written response from MMP anticipates a 45 calendar day estimation of approval and MMP expects to implement the change no later than 10/16/17.

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	** Please note: Should the Plan receive the CMS/DHCS approval prior to the anticipated 45 calendar days; the Plan timeline for implementation will be sooner than 10/16/17.*			**This finding is closed.**
#6: The Plan classified enrollee expressions of dissatisfaction as inquiries rather than grievances.	In order to correct the identified finding, the Plan's Customer Service department conducted trainings on July 27 and July 31, 2017 [Attachment: 6_CS_Staff Meeting Agenda_Sign-in_Sheet], with the Customer Service Staff to establish a clear understanding of how to differentiate between an inquiry and a grievance. The staff was provided with the following information during the training: • A presentation of the DMHC Audit findings, focusing on potential findings #6 [Attachment: 6_DMHC Audit Findings_Customer_Service]; • A review of each case identified as deficient in the audit report, and a discussion about what the error was in those instances; • A Job Aide to be used when determining the difference between an inquiry and a grievance. The Job Aide includes examples of inquires and the definitions for an "inquiry" and a "grievance" [Attachment: 6_Differences Between a Inquiry and a Grievance]; • An updated Desktop Procedure that provides step-by-step instructions for how to handle Medicaid-based services grievances [Attachment: 6_OCC-DTP-Grievance Process-Medicaid based services_Final]. In an effort to ensure sustainability of the resolution and prevent reoccurrence, the Plan's Customer Service department enhanced its existing Quality Monitoring process (Attachment: 6_DTP – Quality Monitoring_Final) to include a daily review of the customer service call log. Effective August 1, 2017, the daily call log review includes an assessment of all calls identified as "grievances" as well as a sample focused review, using data mining to isolate key words, of the remaining calls. If trends, issues, or concerns are identified, the Plan's Customer Service department will conduct refresher trainings for staff, as necessary. Independent of Customer Services' monitoring efforts, the Plan's Audit & Oversight (A&O) department conducts monitoring and	• 6_CS_Staff Meeting Agenda_Sign-in_Sheet • 6_Differences Between a Inquiry and a Grievance • 6_DMHC Audit Findings_Customer_Service • 6_OCC-DTP-Grievance Process-Medicaid based services_Final • 6_DTP – Quality Monitoring_Final	August 1, 2017	**08/07/17** - The following documentation supports the MMP's efforts to correct this finding: - Staff meeting agenda, sign-in sheet, and corresponding PowerPoint presentation, "DMHC Audit Findings Presentation" (07/2717; 07/31/17). The MMP conducted trainings to educate Customer Service Staff on differentiating between inquiries and grievances. - Differences Between an Inquiry and Grievance Job Aid (2017) was developed by the MMP to assist Customer Service Staff in differentiating between inquiries and grievances. The job aid defines and gives examples of both inquiries and grievances. - Grievance Process Desktop Procedure (07/26/17) for the MMP's CSRs provides instructions for processing grievances. It instructs the CSRs in instances where they are unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance - Quality Monitoring Desktop Procedure (07/27/17) which describes the MMP's process for reviewing daily call logs to ensure calls are correctly classified as an inquiry or grievance. **This finding is closed.**

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	auditing of the Customer Service Department's processes. On a monthly basis, A&O reviews the Customer Service call and inquiry logs. A&O selects a sample of ten (10) calls to audit. The audit targets the correct classification of calls in addition to other key elements. Should the Customer Service Department fail to meet 100% compliance in A&O's review, a Corrective Action Plan is issued to the Customer Service Department.			
#7: The Plan misclassified standard grievances as exempt.	In order to correct the identified finding, the Plan's Customer Service department conducted trainings on July 27 and July 31, 2017 [Attachment: 7_CS_Staff Meeting Agenda_Sign-in_Sheet], with the Customer Service Staff to establish a clear understanding of how to identify and resolve exempt grievances and how to identify grievances [Attachments: 7_DMHC Audit Findings_Customer_Service and 7_OCC-DTP-Grievance Process-Medicaid based services_Final]. The staff was provided with the following information during the training: • The Customer Service Team was provided with a presentation of the DMHC Audit findings focusing on potential findings #7 [Attachment: 7_DMHC Audit Findings_Customer Service]; • A review of each case identified as deficient in the audit report, and a discussion about what the error was in those instances; • An updated Desktop Procedure that provides step-by-step instructions for how to handle Medicaid-based services grievances. The Desktop Procedure explains how to identify and categorize an exempt grievance, and details the steps to take when a grievance is not resolved by the next business day [Attachment: 7_OCC-DTP-Grievance Process-Medicaid based services_Final]. Additionally, the Plan's Customer Service department conducted additional training for Customer Service Management on July 28, 2017 [Attachment: 7_Mgmt_Meeting_07282017]. During this training, Customer Service Management was trained on a new process regarding a review of the daily call logs [Attachment: 7_DTP - Quality Monitoring_Final] to ensure the following: • Cases are categorized correctly;	• 7_CS_Staff Meeting Agenda_Sign-in_Sheet • 7_DMHC Audit Findings_Customer Service • 7_OCC-DTP-Grievance Process-Medicaid based services_Final • 7_Mgmt Meeting_07282017 • 7_DTP - Quality Monitoring_Final	August 1, 2017	**08/07/17** - The following documentation supports the MMP's efforts to correct this finding: - Staff meeting agenda, sign-in sheet, and corresponding PowerPoint presentation, "DMHC Audit Findings Presentation" (07/2717; 07/31/17). The training assisted staff in identifying and resolving exempt grievances. Examples of misclassified grievances from the audit were discussed and errors in classification were identified. - Grievance Desktop Procedure (07/26/17) provides step-by-step instructions for processing member grievances. The desktop procedure accurately defines exempt grievances and explains how to appropriately process these. - Quality Monitoring Desktop Procedure (07/26/17) which describes the MMP's process for reviewing daily call logs to ensure exempt grievances are resolved by the next business day. **08/18/17** – -Technical assistance was provided to the MMP to advise that certain grievances (i.e., coverage disputes,

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	• Cases are clearly and correctly identified as either inquiries or grievances; • Exempt grievances are resolved by the close of the next business day; and • Medicaid-based grievances that are not resolved by the close of the next business day are routed to the Grievance and Appeals Resolution Services department for continued research and resolution. In an effort to ensure sustainability of the resolution and prevent reoccurrence, the Plan's Customer Service department enhanced its existing Quality Monitoring process [Attachment: 7_DTP – Quality Monitoring_Final] to include a daily review of the customer service call log, including exempt grievances. If trends, issues, or concerns are identified, the Plan's Customer Service department will conduct refresher trainings for staff, as necessary. Independent of Customer Services' monitoring efforts, the Plan's Audit & Oversight (A&O) department conducts monitoring and auditing of the Customer Service Department's exempt grievance process. On a monthly basis, A&O reviews the Customer Service exempt grievance process to ensure all issues were correctly identified and resolved within 24 hours. A&O selects a sample of ten (10) exempt grievances and reviews the nature of the grievance to determine if the Plan's response appropriately addressed the member's grievance. Should the Customer Service Department fail to meet 100% compliance in A&O's review, a Corrective Action Plan is issued to the Customer Service Department.			disputed health care services involving medical necessity or experimental or investigational treatment) do not qualify for exempt grievance processing. The MMP's monitoring processes should also ensure that these grievances are not captured as exempt as well. (The MMP's existing monitoring processes already look to see that exempt grievances are resolved by the next business day). **This finding is closed.**
#8: The Plan does not maintain a cultural and linguistic services program that includes:(1) goals and objectives; (2) a timetable for implementation and accomplishment of the goals and	The Plan's Cultural and Linguistic Services (C&L) department has updated its existing goals and objectives to include a timetable for the implementation and accomplishment of the goals and objectives [Attachment: 8_Goals & Objectives_2017-2018_Rev 08.02.17] The Plan's C&L Services Plan has been updated to include a narrative explaining the Plan's C&L department organizational chart that describes the oversight and direction to the community advisory committee. The Plan updated policy CMC.4002: Cultural & Linguistic Services	• 8_Goals & Objectives_2017-2018_Rev 08.02.17 • 8_C&L Organizational Chart Explanations_07.28.17 • 8_CMC.4002_Cultural and Linguistics Services_Rev 08.01.17	August 1, 2017 July 31, 2017 August 1, 2017	**08/07/17** - The following documentation supports the MMP's efforts to correct this finding: - Cultural and Linguistic Services 2017 Goals and Objectives (08/02/17) grid. The grid indicates all goals and objectives for 2017 as well as a timetable for implementation and progress on status per quarter.

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objectives; and (3) a narrative explaining the Plan's organizational chart that describes the oversight and direction to the community advisory committee.	[Attachment: 8_CMC.4002_Cultural and Linguistics Services_Rev 08.01.17] to revise and add language in response to identified finding. These changes were approved by the Plan's internal Policy Review Committee (PRC) on July 26, 2017, and will be finalized by the Plan's Chief Executive Officer following DHCS review and approval of the change. The changes include the following: • Section II.B. was modified to indicate that C&L Services programs, goals, objectives, and outcomes are to be reported annually to both the Plan's OneCare Connect (Cal MediConnect) Member Advisory Committee (MAC) and the Plan's Provider Advisory Committee (PAC); • Section II.D. was modified to specify that the C&L Plan must include Goals and objectives, a timetable for implementation and accomplishments of the goals and objectives, and an organization chart showing the key staff persons with overall responsibility for C&L service and activities; and • Section III.A.2. was modified to indicate that the OneCare Connect MAC and the PAC shall provide input on the C&L Plan, including the goals and objectives. • The C&L Manager will begin presenting to the OneCare Connect Member Advisory Committee (OCC MAC) and Provider Advisory Committee (PAC), effective October 31, 2017, to obtain C&L oversight and direction from these community advisory committees. Attachment: 8_C&L Organizational Chart Explanations_08.24.17	**8/24/17 – Follow-up** • 8_C&L Organizational Chart Explanations_08.24.17		- Policy CMC.4002, "Cultural and Linguistic Services" (rev. date 08/01/17) was updated to require on an annual basis for C&L Services to report C&L programs, goals, objectives, and outcomes to the MAC and PAC. **08/21/17** - The following additional documentation supports the MMP's efforts to correct this finding: -MMP's written response (08/18/17) clarifying that the C&L Manager will be the one specifically presenting at both MAC and PAC meetings beginning 10/31/27 and that the objective is to have the MAC & PAC review, discuss, and provide feedback on the 2017 C&L Goal and Objectives grid. **08/24/17** - The following additional documentation supports the MMP's efforts to correct this finding: -"Cultural & Linguistics Services Department" organizational chart (08/24/17) which has been updated to indicate that one of the C&L Manager's responsibilities includes annual reporting to the MAC and PAC on C&L goal and objectives. **This finding is closed.**
#9: The Plan does not measure the time from which the telephone is answered to the	The Plan respectfully requests DHCS's and DMHC's reconsideration of potential deficiency #9. In error, the Plan failed to provide adequate documented evidence and failed to adequately verbally address the Plan's efforts related	• 9_OneCare_Connect_Call Statistics_by_Language_20150701-20161031 • 9_Pacific_Interpreters_CalOptima LanguageLine Metrics Report July 2015 -	N/A	**08/07/17** - The following documentation supports the MMP's efforts to correct this finding: - OneCare Connect Call Statistics

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point at which an enrollee reaches a CSR capable of responding to the enrollee's question in a manner that is sensitive to the enrollee's language and cultural needs.	to the identified deficiency. However, the Plan requests DHCS's and DMHC's review of additional documentation at this time, that the Plan regrets it did not provide at the time of the survey. Since the inception of the Plan's Cal MediConnect line of business, and during the entire review period, the Plan has indeed measured the time from which the telephone is answered to the point at which an enrollee reaches a CSR capable of responding to the enrollee's question in a manner that is sensitive to the enrollee's language and cultural needs. The Plan monitors its internal call center performance results [Attachment: 9_OneCare_Connect_Call Statistics_by_Language_20150701-20161031] on a daily basis. This monitoring includes the total calls received, total calls answered, total calls abandoned, abandonment percentage, average speed of answer, and service level percentage by threshold language. The Plan is able to develop this report internally because the Plan directly employs Customer Service Representatives who can assist enrollees in the Plan's threshold languages. Even when the enrollee's language need is for a non-threshold language, the Plan monitors the performance of its interpreter vendors [Attachments: 9_Pacific_Interpreters_CalOptima LanguageLine Metrics Report July 2015 -October 2016 and 9_VOIANCE_CalOptima Monthly Performance Summary - July 2016 - June 2017].	October 2016 9_VOIANCE_CalOptima Monthly Performance Summary - July 2016 - June 2017		Report (7/1/15 – 10/31/16) demonstrates that the MMP monitors daily the total calls received, the total calls answered, total calls abandoned, abandonment percentage, average speed of answer and service level percentage by threshold language. The report demonstrates the MMP was monitoring the time from which the telephone is answered to the point at which an enrollee reaches a CSR capable of responding to the enrollee's question in a manner that is sensitive to the enrollee's language and cultural needs during the review period. - Pacific Interpreters CalOptima Language Line Metrics Report from 7/15-10/16 and VOIANCE CalOptima Monthly Performance Report serve as evidence that the MMP also monitors the call statistics for members whose language needs are non-threshold languages. **DHCS finds that the MMP was compliant with this requirement during the review period.** **This finding is closed.**

Submitted by: Michael Schrader (signature on file) **Date: 8-7-17**
Title: Chief Executive Officer