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

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

March 3, 2023

Kristen Cerf, Chief Executive 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. Cerf:

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 January 18, 2022 through January 27, 2022. The audit covered the period of January 1, 2021 through December 31, 2021.

All items have been evaluated and DHCS accepts the MCP's submitted Corrective Action Plan (CAP). The CAP is hereby closed. The enclosed documents will serve as DHCS' final response to the MCP's CAP. Closure of this CAP does not halt any other processes in place between DHCS and the MCP regarding the deficiencies in the audit report or elsewhere, nor does it preclude the DHCS from taking additional actions it deems necessary regarding these deficiencies.

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

If you have any questions, please reach out to CAP Compliance personnel.

Sincerely,

[Signature on file]

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

Enclosures: Attachment A (CAP Response Form)

cc: Lyubov Poonka, Chief
CAP Compliance Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

Anthony Martinez, Lead Analyst
CAP Compliance Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

Emmy Wong, Contract Manager
Medi-Cal Managed Care Division
Department of Health Care Services

ATTACHMENT A
Corrective Action Plan Response Form

Plan: Blue Shield of California Promise Health Plan **Review Period: 01/01/21 – 12/31/21**

Audit Type: Medical Audit and State Supported Services **Onsite Review: 01/18/22 – 01/27/22**

MCPs are required to provide a CAP and respond to all documented deficiencies included in the medical audit report within 30 calendar days, unless an alternative timeframe is indicated in the CAP Request letter. MCPs are required to submit the CAP in Word format that will reduce turnaround time for DHCS to complete its review. According to ADA requirement, the document should be at least 12 pt.

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. The MCP shall directly address each deficiency component by completing the following columns provided for MCP response: 1. Deficiency Number and Finding, 2. Action Taken, 3. Implementation Documentation, and 4. Completion/Expected Completion Date. The MCP will be required to include project timeline with milestones in a separate document for each finding. Supporting documentation should accompany each Action Taken. If supporting documentation is missing, the MCP submission will not be accepted. For policies and other documentation that have been revised, please highlight the new relevant text, and include additional detail such as title of the document, page number, revision date, etc. in the column "Supporting Documentation" to assist DHCS in identifying any updates that were made by the plan. For deficiencies that require short-term corrective action, implementation should be completed within 30 calendar days. For deficiencies that may be reasonably determined to require long-term corrective action for a period longer than 30 days to completely remedy or operationalize, the MCP is to indicate that it has initiated remedial action and is on the way towards achieving an acceptable level of compliance. In those instances, the MCP will be required in addition to the above steps, to include the date when full compliance will 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.

Please note, DHCS expects the plan to take swift action to implement improvement interventions as proposed in the CAP, therefore DHCS encourages all remediation efforts to be in place no later than month 6 of the CAP, unless prior approval for an extended implementation effort is granted by DHCS.

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 integrate review of PA and appeal reports into its QIS.	1. Develop a pre-committee workflow process that includes the review of authorization denials, deferrals, modifications, and appeals. 2. Establish a standing template for reporting prior authorization and appeals data to Medical Services Committee (MCS) 3. Report findings/action items discussed in pre-committee meeting at MCS 4. Report findings/action items discussed in pre-committee meeting at Quality Management Committee (QMC)	1. 2022 UM_AGD Workgroup Charter 1. Standing Agenda 2. MSC AGD 2022 - DRAFT 2. Denials to MSC. 3. MSC AGD Q3 2022 4a.AGD Section QMC 4b.Subcommittee_MSC Promise	1. Completed by 8/22/2022 2. Completed by 9/6/2022 3. Completed by 9/13/2022 4a. Completed by 12/15/2022 4b. Completed by 12/15/2022	The following documentation supports the MCP's efforts to correct this finding: **Policy & Procedures** • UM/AGD Workgroup Charter and standing agenda demonstrates the MCP has a process to review of authorization denials, deferrals, modifications, and appeals. Standing agenda includes: Denial volume and percentage Appeal volume Overturn/Uphold Percentages Types of appeals overturned, to include reasons why overturn and specialty • Draft Appeals and Grievance Department MSC and UM PHP Workplan Q2 created to report PA and appeal to the MSC. **Monitoring & Oversight** Medical Services Committee Qx Data Report for Q2 2022 discusses patterns in the MCP's G&A data. "Q3 2022 AGD Highlights and Subcommittee MSC Promise" demonstrate the MCP is reporting finding and action items regarding PA and appeals to both the QMC and MCS meetings. **The Corrective Action Plan for Finding 1.1.1 is accepted.**

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1.2.1 Prior Authorization Criteria The Plan did not ensure medical criteria was consistently applied and used to adjudicate PA requests.	1. Implement new workflow to ensure routine communication of all updated and/or new medical policies and clinical guidelines to clinical staff members. As part of the process, the CMO or CMO's medical director designee will send email communications to MDs and other clinical staff on key Medical policies. Routine IRR (Inter-rater Reliability) testing will be conducted to ensure understanding and compliance with medical policies. 2. Conduct semi-annual review of medical policies and clinical guidelines to ensure they are current. 3. CMO designated Medical Director to be assigned	1a.Sample_Medical Director Bi-Weekly Meeting 1b. Sample IRR Records 2a. MSC Q2 2022 Meeting Minutes_6.28.22_Signed 2b. MSC Email Vote to Endorse Promise Review and Usage of MCG Criteria 2c. MSC Vote Tally 2d. MSC Vote Responses 3.Reg Intake Meeting Agenda_Minutes	1a. Completed by 8/31/2022 1b. Completed by 8/31/2022 2a. Completed by 12/15/2022 2b. Completed by 12/15/2022 2c. Completed by 12/15/2022 2d. Completed by 12/15/2022 3.Completed by 5/31/2022 4a-4f. Completed by 5/2/2022 5a-5c. Completed by 10/14/2022	The following documentation supports the MCP's efforts to correct this finding: **Policy & Procedures** • "Medi-Cal Regulatory Intake and Triage Weekly Meeting Minutes" (07/21/22) demonstrates the assignment of the Medical Director to participate in the weekly Medi-Cal Regulatory Intake and Triage workgroup where the MCP reviews and discusses new regulatory changes and DHCS communications. (3. Reg Intake Meeting Agenda_Minutes). • "Medical Directors Bi-Weekly Meeting Minutes" (May 2022 – June 2022) demonstrates the implementation of bi-weekly meetings with MDs and physician reviewers to discuss new APLs, joint case reviews, and application of medical necessity criteria. (4a - 4f Medical Director Bi-weekly Meeting Minutes). • "Prior Authorization CAP Meeting Minutes" (09/30/22) demonstrates the process where all identified high risk services prior authorizations will require secondary review by an additional medical director. • "BSCPHP, Medical Director Job Description and Senior Medical Director Job Description" demonstrates the hiring of a MD to be responsible for

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	to participate in the weekly Medi-Cal Regulatory Intake and Triage workgroup where the Plan reviews and discusses new regulatory changes and DHCS communications. This workgroup reviews newly issued DHCS All Plan Letters (APLs) before conducting an impact assessment and implementation activities. 4. Implement bi-weekly meetings to include Promise Medical Directors and physician reviewers. Meeting agenda will demonstrate including but not limited to: Discussion on newly issued APLs and their impact assessments, joint case reviews, as necessary, application of medical necessity criteria, IRR findings, etc. Meeting minutes will be maintained outlining the topics of discussion and any action items to occur.	4a. Sample_ 05.02.2022 Medical Director Bi-weekly Meeting Minutes 4b. 5-02 Minutes_Sample _Live r Transplant Criteria LB 2.1.2022_Final1 1 4c. 5-02 Minutes_Sample _Rev ised-Treatment-Policy-for-the-Management-of-Chronic-Hepatitis-C-12921 (1) 4d. Sample_05.16.2 022 Medical Director Bi-weekly Meeting Minutes 4e. Sample_06.02.2 022 Medical Director Bi-	6a. Completed by 7/31/2022 6b. Completed by 7/31/2022 7a. Completed by 9/30/2022 7b. Completed by 9/30/2022	UM activities, PA criteria, and oversight of physician reviewers. (6b. JD - BSC PHP Medical Director, Senior Medical Director). **Training** • "IRR Case Study #25-68 and #25-69" demonstrates that routine IRR testing will be conducted to ensure understanding and compliance with medical policies. (1b. Sample_IRR Case Study 1_25-68 QC Test, 1b. Sample_IRR Case Study 2_25-69 QC Test). • "Q2 2022 Meeting Minutes" (06/28/22) demonstrates the approval and adoption of DHCS Medi-Cal UM criteria and MCG Care Guidelines, 2021, 25th Edition. (2a. MSC Q2 2022 Meeting Minutes_6.28.22, Page 6). **Monitoring & Oversight** • "Medical Directors Bi-Weekly Meeting" (09/06/22) demonstrates that an MD has been assigned to participate in the weekly Medi-Cal Regulatory Requirement Intake and Triage workgroup meeting. All identified high-risk services with PA will require a secondary review by an additional MD for a span of 3 months. Logs will be maintained of all decision and findings from quarterly audits of random sample of MD approvals and denials. (1a. Medical Director Bi-weekly Meeting, Slide 10). • "PHP Denial Rationale Workgroup" (08/22/22) demonstrates that the MCP has an agenda item for discussing the CAP for finding 1.2.1 and the plan for remediation. (7a. PHP Denial Rational Workgroup Minutes).

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	5. Implement a process where all identified high risk services prior authorization denials will require secondary review by an additional medical director for a span of three months. The tandem decision process will occur real-time and key learnings tied to decision making will be documented and shared with other MD. 6. Designate a Promise Medical Director as the primary medical director responsible for Utilization Management activities, including prior authorization criteria and oversight of physician reviewers. 7. Conduct quarterly audits of random sample of Approvals and Denials by Medical Directors and physician reviewers. Maintain log of all decisions and audit findings. Implement specific corrective actions when deficiencies (e.g. MD did not apply criteria,	weekly Meeting Minutes 4f. Sample_06.13.2022 Medical Director Bi-weekly Meeting Minutes 5a. Prior Auth Minutes 5b. Medi-calCMC Closed MTD 5c. Medi-Cal CMC Closed Appeals 2022 YTD_diagnoses 6a. Sr. MD Job Description 6b. MD Job Description 7a. Sample PHP Denial Rationale Workgroup Minutes 7b. Sample Denial File Audit		• "Excel Spreadsheet - Denial File Audit Report" demonstrates that the MCP has a monitoring process to track and trend denied PA overturned appeals to identify reoccurring issues. The MCP' conducts quarterly audits of random samples of Approvals and Denials by MDs and physician reviewers. (7b. 2022_09 Denial File Audit Report). **The Corrective Action Plan for Finding 1.2.1 is accepted.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	missed TAT).			
1.3.1 Medical Decisions in the Expedited Appeal Process The Plan did not ensure that expedited appeals were reviewed by a health care professional with clinical expertise in treating the member's condition or disease.	1. Revised Appeals and Grievance (AGD) Beneficiary Grievance Management System policy and procedure (P&P) and workflows to ensure appeals meeting expedited criteria are evaluated by the AGD Nurses and is referred to the MD for clinical review as needed. 2. Enhanced staff desk-level procedures, templates and workflows to define, review and expand list of services or criteria qualifying as expedited based on DHCS definition of an expedited request. 3. Developed templates for AGD Nurses and MDs to utilize to document findings and rationale for changing statuses from standard to expedited.	1a. P&P_10.19.5 Beneficiary_Grievanc e_Management_Syst em 1b. AGD Nurse Appeal and Grievance Expedited Request Review Guideline_2082 2a. Expedite Case Template 2b. Staff guidance on flagging expedited cases 2c. AGD Nurse Appeal and Grievance Expedited Request Review Guideline_2082	1a. Completed by 7/30/2022 1b. Completed by 7/30/2022 2a.Completed by 6/15/2022 2b.Completed by 5/25/2022 2c. Completed by 7/30/2022 3a. Completed by 6/15/2022 3b. Completed by 6/15/2022 4. Completed by 7/30/2022 5a. Completed by 8/31/2022 5b. Completed by 10/31/2022	The following documentation supports the MCP's efforts to correct this finding: **Policies & Procedures** • Revised Policy 10.19.5 Beneficiary Grievance Management System outlines the process for referring expedited appeals with clinical issues to the Medical Director or peer review designee for medical necessary determination. • The Medical Director will determine if expedited grievances qualify as expedited based upon established criteria. • All quality-of-care concerns with clinical issues must be reviewed by a Medical Director. • If an expedited grievance does not meet expedited criteria, the member is notified verbally and in writing of their right to grieve the determination. • Policy requires decision-maker shall be a health care professional with clinical expertise in treating a beneficiary's condition or disease if any of the following apply: • An appeal of an Adverse Benefit Determination is based on lack of medical necessity. • A Grievance regarding denial of an expedited resolution of an Appeal. • Any Grievance or Appeal involving clinical issues. • If the appeal is for a clinically urgent situation, the coordinator will

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	4. Revise AGD workflow for non-clinical and clinical staff to ensure expedited appeals are assessed, reviewed and resolved by all members of the AGD Team including licensed health-care professional. 5. Revise QA monitoring process for the oversight of expedited Appeals to ensure cases are assessed, reviewed and is resolved by the AGD Team including the clinical staff (AGD Nurses and MD) 6. Enhance Committee reporting procedures to ensure that Appeals data, especially tied to key findings and resolution, trends etc. are being reported to various committees.	3a. Expedite Case Template 3b. Review of Upcoding_Template 4. AGD Nurse Appeal and Grievance Expedited Request Review Guideline_2082 5a. Clinical AGD Scorecard - Appeals 5b. MCS Clinical Appeal Audit-Error Report August 2022 5c. MCS Clinical Appeal Audit-Quality Detail Report August 2022 5d. Sample_AGD Clinical Scorecard for Dr. Howatt for	5c. Completed by 10/31/2022 5d. Completed by 10/31/2022 5e. Completed by 10/31/2022 6a. Completed by 8/31/2022 6b. Completed by 8/31/2022	immediately forward the case to the assigned RN/LVN for review. The assigned nurse will then request an immediate review by the medical director for clinical review. The Plan revised P&P" 10.19.5 Beneficiary Grievance Management System" to include the newly implemented QA monthly monitoring process for the oversight of Appeals. (Rev. December 2022) The Plan developed staff desk-level procedures, templates and workflows to define, review and expand list of services or criteria qualifying as expedited based on DHCS definition of an expedited request. • Expedite Case Templates that outline the process used by Medical Director to determine whether cases meet the clinical definition or meet the clinical scenario of an expedited case, including de-escalation (expedited to standard) or (standard to expedited). This template is not a medical necessity review, only an assessment of whether the case meets or does not meet expedited criteria. • Escalation Criteria provides regulatory definition for what meets expedited criteria and outlines escalation criteria. • Nurse Appeal and Grievance Expedited workflow outlines process to review and evaluate expedited requests. **Monitoring & Oversight** The Plan developed and/or deployed various monthly self-monitoring processes to detect and prevent future non-compliance. The Plan submitted the following supporting documentation that address the audit finding:

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		A22195123931 5e. Sample_AGD Clinical Scorecard for Dr. Howatt for A22203149491 6a. Sample Pre-Committee Meeting Minutes 6b. Sample Committee deck		Revised QA monthly monitoring process for the oversight of Appeals to ensure cases are assessed, reviewed and is resolved by the AGD Team including the clinical staff (AGD Nurses and MD) • Clinical AGD Scorecard - Appeals • MCS Clinical Appeal Audit- Error Report • MCS Clinical Appeal Audit- Quality Detail Report Measures: Regulatory Accuracy, including appropriate priority File Documentation Case Accuracy Timeliness/Compliance • Sample_AGD Clinical Scorecard for A22195123931 • Sample_AGD Clinical Scorecard for A22203149491 **The Corrective Action Plan for finding 1.3.1 is accepted.**
1.4.1 Medical Director Involvement in the Grievance Process The Plan's Medical Director did not actively participate in the Plan's grievance procedures.	1. Updated the Appeals and Grievance (AGD) Beneficiary Grievance Management System policy and procedure (P&P) Chief Medical Officer (CMO) / Medical Director (MD) involvement verbiage. 2. Trained MDs on end-to-end AGD operations for e.g. oversight and monitoring of	1. P&P_10.19.5 Beneficiary_Grievanc e_Management_Syst em 2a. Training AGD MD 2b. Training AGD MD Exp 3a. JD – BSC	1. Completed by 6/30/2022 2a.Completed by 6/30/2022 2b. Completed by 7/21/2022 3a.Completed 6/16/2022 3b.Completed 6/16/2022	The following documentation supports the MCP's efforts to correct this finding: **Policies & Procedures** Updated Policy 10.19.5 Beneficiary Grievance System outlines the Chief Medical Officer and Medical Director's roles and responsibilities in providing oversight of the Plan's grievance system. Chief Medical Officer is responsible for the Plan's grievance system and actively participates in the grievance process.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	case categorization, handling QOC cases, expedited cases, downgraded cases, case reviews, drafting resolution letter narratives etc. 3. Updated existing job descriptions for both CMO and MD responsibilities for AGD. 4. Identified and designated MDs who will play an active role in the end-to-end clinical review process. 5. Develop process/workflow to establish CMO / MD oversight of non-clinical operations (e.g. case categorization conducted by Customer Care / Intake teams, handling of Quality of Service cases etc.) and documentation expectations. 6. Develop process/workflow to establish CMO / MD oversight of clinical operations (Clinical Oversight Team + Potential Quality Issue)	PHP CMO 3b. JD – BSC PHP Medical Director 3c. JD – BSC PHP Senior Medical Director 4. Designated MDs supporting AGD Operations 5.Case Consult Templates 6. Case Consult Templates 7a.Case selection for MD AG case review 9.29.22 7b. MD AG Case Review Meeting Minutes_ 9.29.22 8. MD Oversight 9. RE_ Review	3c.Completed 6/16/2022 4.Completed 3/31/2022 5.Completed 7/30/2022 6.Completed 7/30/2022 7a. Completed by 7b. Completed by 8. Completed by 12/15/2022 9. Completed by 9/30/2022 10a. Completed by 10/14/2022 10b. Completed by 10/14/2022	The Medical Director provides oversight of the grievance system, including: • Continuous review of the grievance system operations to identify any emergent patterns of grievances. • Review of the Plan grievance and appeals policies and procedures. • Ensuring that qualified medical personnel render medical decisions. • Review of the quarterly and annual regulatory grievance reports. • Chair or participate on the applicable quality assurance committees in support of grievance reporting, including in the Medi-Cal Service Committee (MSC) and the Plan's Board Quality Improvement Committee (BQIC) The Plan Medical Director will provide support in addressing the responsibilities by reporting any findings to the Chief Medical Officer in a regular cadence. The Plan's CMO or designated Medical Director will work closely with the Plan's Clinical Manager of Operations for AGD, and the Sr. Manager of Operations for AGD to ensure that member grievances involving clinical issues are properly classified and reviewed by qualified medical personnel. Plan updated job descriptions for CMO, Senior MD and MD position summaries, education and experience, and specific roles and responsibilities relating to the Grievance and Appeals system. **Training**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	operations and documentation expectations. 7. Develop a process for CMO to review cases with MD determinations. 8. Establish an inter-rater reliability and oversight process on MD case work 9. Establish internal controls and/or audit processes to ensure that MD oversight pertaining to end-to-end AGD workflows is occurring regularly and per agreed upon guidelines 10. Identify missing reports / information that should be going to Committees and adjust process as required. Develop a recurring review process, prior to committee presentation, to ensure that appropriate analysis and trending of the data is presented and to identify any potential actions that are needed from the committees. Review process	MD case Work Pertaining to Appeals and Grievances 10a.AGD Partnership Agenda 10b.UM AGD PreCommittee Meeting Minutes		Medical Director roles and responsibilities training included overview of the following: 1. Medical Director responsibilities 2. Clinical triage for the assessment of expedited AGD cases 3. AGD case types and categories 4. Potential Quality Issue(PQI) identification and referral 5. AGD Workflows, Templates and Resources 6. AGD Documentation Requirements and Templates Expedited and De-Expedited Training • Perform the AGD Medical Director responsibilities for the management of grievance and appeals. • Identify and manage the AGD case requirement for expediting and de-expediting grievance and appeals. • Apply the skills learned to properly document the correct status • Expedite is 36 hours and standard is 30 days **Monitoring & Oversight** Monthly Medical Director Appeals and Grievance Case Review Plan submitted meeting minutes as evidence medical directors are reviewing appeals and grievances and trending analysis. Documentation includes review of criteria applied, decision-making, physician documentation, reviewer documentation, resolution letters, and education. Plan is developing and deploying an internal audit process to continuously self-monitor to detect and prevent future non-compliance.

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	should occur at least 1 week before the Committee meeting. Review current reporting cadence to the various committees and ensure that it is adequate.			• (Error report/statistics report), will capture deficiencies. **Decision: Audit Approach for MDs** CMO to set up monthly check-ins with Medical Directors Quick fixes in MD narrative/verbiage on daily cases feedback to MDs, etc. Pivot to 8/30 methodology quarterly **The Corrective Action Plan for Finding 1.4.1 is accepted.**
1.4.2 Medical Decisions in the Grievance Process The Plan's Medical Director did not ensure that member grievances involving clinical issues were properly classified and reviewed by qualified medical personnel.	1. Updated Desk Level Procedures with definitions for grievances as defined by regulatory and accreditation requirements. Medi-Cal Regulatory Grievance Types: QOS, QOC. 2. Revised P&P to align with definitions and documentation supporting the intake process of the clinical nurse review for all grievances to ensure appropriate categorization or any mis-categorization. 3. Trained AGD clinical and non-clinical staff including Medical Directors on revised definitions for grievance	1. Blue Shield Promise_Intake Process_MHK 2. P&P_10.19.5 Beneficiary_Grievance_Management_System 3. Grievance Definition Training 4a. Case Consult Templates 4b. Management of Quality-of-Care Grievances Training_FINAL 05052022	1. Completed by 4/29/22 2. Completed by 6/30/22 3. Completed by 3/25/22 4a. Completed by 7/30/2022 4b. Completed by 5/4/2022 5. Completed by 7/30/2022	The following documentation supports the MCP's efforts to correct this deficiency: **Policies & Procedures** Intake Process defines QOS and QOC grievances and outlines grievance triage process and clinical oversight. Updated Policy 10.19.5 Beneficiary Grievance Management System (2/18/22) which defines QOS and QOC grievances and outlines clinical oversight, including: All grievances are submitted to the clinical team for clinical oversight and review for potential quality issues. QOC concerns with clinical issues must be reviewed by the Medical Director. **Training** Medi-Cal Appeals and Grievances includes identification of grievances by type and category, grievances with clinical issues must be reviewed by a physician.

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	categories (QOC, QOS and/or both). 4. Developed process/workflow/reporting to establish CMO / MD oversight of non-clinical operations and documentation expectations. 5. Revised monthly grievance log audit Desk Level Procedure (DLP) to review for misclassifications and report results in appropriate committees for oversight of misclassifications.	5. Grievance Log Audit DLP		Clinical Oversight Team – Clinical oversight team nurse reviews grievances to categorize QOS, QOC, both and PQI, routing to Medical Director for review and resolution. Grievance Log DLP Monthly review of grievance log by Medical Director who will audit for the following: Appropriate identification of all issues/case categorization of non-clinical, clinical, and PQI issues, and ensure clinical grievances are forwarded to the Medical Director. Medical Director Case Review Meeting – Evidence of monthly meeting with CMO/Medical Director for review of grievance handling and trending analysis. **The Corrective Action Plan for Finding 1.4.2 is accepted.**
2. Case Management and Coordination of Care				
2.1.1 IHA Completion The Plan did not ensure the provision of complete and comprehensive IHAs.	1. Received detailed audit information from DHCS audit and re-reviewed each medical record to determine root cause of failure to adequately document Initial Health Assessment (IHA) visits as is required by DHCS. Review indicates PCPs do not consistently document all	1. 2022 DHCS - Promise IHA Medical Record Audit Verification Findings 2a. 2. 2022 DHCS IHA - Blue Shield Promise PCP	1. Completed by 7/15/2022 2a. Completed by 7/25/2022 2b. Completed by 8/15/2022 2c. Completed by 9/15/2022	The following documentation supports the MCP's efforts to correct this finding: **Policies & Procedures** Plan revised Policy 70.29.2.14 - IHA Oversight which outlines the following: Plan will ensure timely access to an IHA within 120 days of enrollment for pediatric and adult members. The components of an IHA include comprehensive medical history, health education needs, physical

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	aspects of the IHA visits despite Blue Shield Promise PCP trainings regarding how to complete an IHA and how to document all aspects of the IHA in the member's medical record. 2. a. Drafted Blue Shield Promise PCP IHA audit findings corrective action plan letter containing specific IHA educational material for each PCP regarding how to conduct a comprehensive IHA and how to document a complete IHA visit in their medical records. b. Send Blue Shield Promise PCP IHA audit findings corrective action plan letter containing specific IHA educational material for each PCP regarding how to conduct a comprehensive IHA and how to document a complete IHA visit in their medical records. The CAP contains an attestation statement that the	IHA Audit Findings CAP Letter 2b. 2022 DHCS IHA - Blue Shield Promise PCP Attestation Form IHA Audit Findings 2c. 2022 DHCS - Promise IHA PCP CAP Tracking Tool 3.70.29.2.14_Initial_Health_Assessment_Oversight_Policy and Procedure_1-22-22 4.70.29.2.14_Initial_Health_Assessment_Oversight_Draft_9-12-22	3. Ongoing, resumed 10/1/2022 4. Completed by 9/15/2022	assessment, completion of SHA, and preventive care and treatment. Member and provider education on the importance of IHAs and immunizations. Plan produces monthly new member eligibility lists for PCPs. IHA Coordinators are required to make a minimum two documented attempts to contact members and provide education to members and assist members with scheduling IHA appointments. Call outcome and ensuing activities are entered into an internal database and are reportable. Reports are compared to encounter data to assess timely access. Quarterly IHA medical record reviews are used assess the quality and completion of IHAs, including: Timeliness, documentation, components, arrangements for follow up, preventive services recommended, immunization status, scheduling, parent refusal documentation. Medical Record Review results and findings are shared with PCP/IPAs, along with resources and guidelines that will assist providers to meet IHA requirements. Corrective action may be required. Continued non-compliance will result in escalation and review by the Credentialing Committee to determine additional corrective action and/or continued network participation. Additionally, analysis, results and subsequent activities will be reported to the Quality Management Committee meeting, at least annually.

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	PCP must sign and date and return to Blue Shield Promise IHA Audit team to confirm that the PCP has reviewed the Blue Shield Promise PCP IHA audit findings corrective action plan letter and IHA educational material and agree to comply and conduct comprehensive IHAs and document all required aspects of the IHA in their medical records. c. Track all Blue Shield Promise PCP corrective action plans and ensure receipt of signed and dated attestation that the PCP has reviewed the Blue Shield Promise PCP IHA audit findings corrective action plan letter and IHA educational material and agree to comply and conduct comprehensive IHAs and document all required aspects of the IHA in their medical records. 3. On 10/1/2021, the Plan resumed quarterly IHA audits			**Monitoring & Oversight** Plan conducts quarterly medical record review audits to assess quality and completion, including: •Timeliness of the IHA appointment •Documentation of attempts to perform an IHA at subsequent office visit(s) until all components of the IHA are completed, including member refusal. •Components of the IHA completed. The IHA Medical Record Review results and findings are provided to the physician/clinic and or the IPA, along with resources and guidelines that will assist the provider to meet IHA requirements. Corrective action plans may be required to address noncompliance or other findings. Plan developed an IHA CAP template letter which outlines the requirements of an IHA. Plan developed an Attestation form which must be signed and dated by a PCP and returned within 14 days. The attestation serves as an acknowledgement the PCP has reviewed information about IHA comprehensive exams, medical record documentation requirements, etc. Plan developed an IHA PCP Tracking Log template which includes date CAP sent, attestation due date, date received, and follow up attempts, results. Plan submitted two CAP examples as evidence of monitoring and oversight, including IHA CAP template letter, training sign in sheets, completed IHA audit tool.

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	and IHA educational efforts after temporarily ceasing audits and IHA educational efforts due to Public Health Emergency (PHE) during COVID 19 pandemic. Blue Shield Promise PCP IHA medical records and issue corrective action plans containing specific IHA educational material for each PCP regarding how to conduct a comprehensive IHA and how to document a complete IHA visit in their medical records as needed to ensure the provision of comprehensive IHAs for all Blue Shield Promise members. 4. Revise IHA Medical Record Audits Policy and Procedure to include a new escalation process, and outline actions to be taken for PCPs who remain non-compliant with IHA medical record documentation, despite re- education, corrective action plans, and re-audits.			Plan submitted IHA Medical Record Audit Metrics as evidence Plan is conducting quarterly IHA audits for timeliness and required documentation. **The Corrective Action Plan for Finding 2.1.1 is accepted.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
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 an effort for a more seamless provider experience and to increase provider compliance with PCS form requirements, the Plan combined the PCS and TAR forms, which had a combined total of three pages, into a combined form with a total of one page. This was reviewed and approved by our DHCS contract manager. 2. In an effort to avoid impacting member access to transportation services, the Plan has implemented a proactive process to identify members 45 days prior to expiration of valid PCS and to conduct provider and member outreach, and terminate rides if PCS expires without renewal.	1. BSCPHP NEMT PCS 2a. Blue Shield Promise NEMT Proactive Outreach Process 2b. KB 072722_DN00349 – Transportation Authorization Expiration Outreach	1. Completed by 11/2022 2. Completed by 7/12/2022	The following documentation supports this finding: **Policies & Procedures** The Plan updated P&Ps to address the gap that contributed to the deficiency: • P&P "10.31.1 NEMT & NMT Services" was amended to include that the Plan will utilize the DHCS approved *Request for NEMT – PCS* combined Treatment Authorization Request (TAR) & PCS form. The Plan will ensure that the *PCS* form is completed & submitted before NEMT services can be authorized & provided to the member. [C. Policy, NEMT, NEMT PCS, page 2] The Plan will utilize the DHCS approved PCS/TAR form to authorize the appropriate mode of service prescribed by the provider. The Plan will not modify an NEMT authorization or change the modality outlined in the PCS form or downgrade the members' level of transportation from NEMT to NMT once the treating physician prescribes the form of transportation on the *Request for NEMT – PCS* form. [C. Policy, NEMT, page 2] • BlueShield PCS/TAR form ○ The revised PCS/TAR form was reviewed & approved by MCOD. The form includes all necessary components to ensure the appropriate level of services is determined for Medi-Cal members.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments

				Monitoring & Oversight
				
				The Plan demonstrated an internal auditing process to continuously self-monitor to detect and prevent future non-compliance:
				
				• BlueShield PCS/TAR Form
				  ○ The Plan identified as part of the root cause of this finding to be the complexity for providers to submit two separate forms (PCS & TAR). The Plan since combined the two forms to include all necessary components & minimized to one page. This form has been reviewed & approved.
				
				• 10.31.1 NEMT & NMT Services
				  ○ The Plan's transportation broker oversight team & the Utilization Management team will monitor compliance on a monthly basis through a custom dashboard. The dashboard shows all NEMT rides that occur each month. The Plan researches the rides flagged as non-compliant to determine root cause & implements corrective action with the provider or the Plan's staff, as applicable. [10.31.1 E. Monitoring, NEMT PCS Compliance, page 12]
				
				• The Plan provided evidence of 100% of the 2,346 rides July 15 – August 31, 2022 had authorization and PCS on file. [Attch. B. Sept. 2022 Response]
				
				The Corrective Action Plan for finding 3.8.1 is accepted.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
3.8.2 Treatment Authorization Request The Plan did not consistently require PA for NEMT services.	1. In an effort for a more seamless provider experience and to increase provider compliance with PCS form requirements, the Plan combined the PCS and TAR forms, which had a combined total of three pages, into a combined form with a total of one page. This was reviewed and approved by our DHCS contract manager. 2. In an effort to avoid impacting member access to transportation services, the Plan has implemented a proactive process to identify members 45 days prior to expiration of valid PCS and to conduct provider and member outreach, and terminate rides if PCS expires without renewal.	1. BSCPHP NEMT PCS 2a. Blue Shield Promise NEMT Proactive Outreach Process 2b. KB 072722_DN00349 – Transportation Authorization Expiration Outreach	1. Completed by 11/2022 2. Completed by 7/12/2022	The following documentation supports this finding: **Policies & Procedures** The Plan updated P&Ps to address the gap that contributed to the deficiency: • P&P 10.31.1 NEMT & NMT Services o The policy was amended to include that the Plan will ensure that the PCS form is completed & submitted before NEMT services can be authorized & provided to the member. [C. Policy, NEMT, NEMT PCS, page 2] o The Plan will ensure there are no limits to receiving NEMT services as long as the member's medical services are medically necessary, & the member has prior authorization via a PCS form. [C. Policy, NEMT, page 2] • BlueShield PCS/TAR form o The revised PCS/TAR form was reviewed & approved by MCOD. The form includes all necessary components to ensure the appropriate level of services is determined for Medi-Cal members. **Monitoring & Oversight** The Plan demonstrated an internal auditing process to continuously self-monitor to detect and prevent future non-compliance: • 10.31.1 NEMT & NMT Services o The Plan's transportation broker oversight team & the Utilization

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				Management team will monitor compliance on a monthly basis through a custom dashboard. The dashboard shows all NEMT rides that occur each month. The Plan researches the rides flagged as non-compliant to determine root cause & implements corrective action with the provider or the Plan's staff, as applicable. [10.31.1 E. Monitoring, NEMT PCS Compliance, page 12] • BSCPHP_NEMT Proactive Outreach Process o The Plan has implemented a proactive process that addresses upcoming expiring PCS: ▪ The Proactive outreach process produces a weekly report that includes a list of members with PCS expiring within 45 days. Outreach is to be conducted by phone to providers, escalating to in person collection. ▪ Member outreach is conducted concurrently to notify member of upcoming expiration & cancellation of upcoming rides due to unsuccessful renewal of PCS. • KB 072722_DN00349_Transpor Auth Exp Outreach o Demonstrates the Plan's workflow to its NEMT Proactive Outreach Process – this provides a visual for the written process the Plan demonstrates in BSCPHP_NEMT Proactive Outreach Process. This addresses upcoming expiring PCS. • The Plan provided evidence of 100% of the 2,346 rides July 15 – August 31, 2022 had authorization and PCS on file. [Attch B. Sept. 2022 Response] **The Corrective Action Plan for finding 3.8.2 is accepted.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
3.8.3 Non-Enrolled NEMT Transportation Providers The Plan did not ensure contracted NEMT providers were enrolled in the Medi-Cal program.	1. The Plan's transportation provider will not enter into agreements with subcontractors to provide services to the Plan's members if they do not have evidence of a pending application with DHCS. The Plan's provider has made a policy change to not allow subcontractors to perform trips for Medi-Cal members if the subcontractor is not successfully enrolled within 120 days of their initial application submissions to DHCS, unless they have an approved emergency enrollment application (crossover application) during the public health emergency (PHE). The Plan's transportation provider is requiring its subcontractors with pending applications to send	1. Excerpt from Call the Car 80.6.9 Initial Credentialing of Subcontracted Providers 2.10.31.3 NMT NEMT Medi-Cal Enrollment Monitoring	1. Completed by 6/1/2022 2. Completed by 8/3/2022	The Plan submitted the following documentation in support of this finding: **Policies & Procedures** • 10.31.3 NEMT & NMT Medi-Cal Enrollment Monitoring o The Plan developed & implemented its P&P "10.31.3 NEMT & NMT Medi-Cal Enrollment Monitoring" to address the gap that contributed to the deficiency. The Plan is monitoring enrollment of transportation providers through weekly updates provided by the transportation broker & monthly monitoring through provider validation through the Open Data Portal. [10.31.3, E. Monitoring, page 3] **Monitoring & Oversight** The Plan identified, developed, and deployed an internal auditing process to continuously self-monitor to detect and prevent future non-compliance: • P&P "10.31.3 NEMT & NMT Medi-Cal Enrollment Monitoring" demonstrates the Plan's various monitoring activities; requiring its transportation broker to review its transportation roster daily & submit an updated roster weekly to the Plan. On a monthly basis, the Plan will use the weekly network reports submitted & validate all providers using the Open Data Portal. Any providers unable to successfully enroll or denied, will be removed immediately. If termination impacts member access, DHCS will be notified & the Plan will submit a plan of action for continuity

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	daily updates of their application status. 2. The Plan implemented an enhanced oversight process where the Plan's transportation provider will deliver a full subcontractor list with all subcontractors' status to the Plan at least weekly and notify the Plan any time there is a status change of any subcontractor, including approval by DHCS, denial by DHCS, or suspension. The Plan will validate the subcontractor status monthly by confirming the status on the DHCS portal. The Plan will monitor subcontractors with pending applications monthly to ensure they do not drive Medi-Cal members after 120 days. The Plan will require immediate corrective action for any deficiencies identified.			of services. [10.31.3, E. Monitoring, page 3] • Transportation Roster "BSCPHP_NEMT_NMT Medi-Cal Enrollment Roster_082022" demonstrates the Plan's monthly validation report, based off of the transportation broker's weekly network report that is submitted. The roster includes how many providers were sampled, confirming all were active & in good standing. This roster validation takes place monthly. **The Corrective Action Plan for finding 3.8.3 is accepted.**
4. Member Rights				

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
4.1.1 QOC Grievance Reviews The Plan did not refer QOC grievances to its Medical Director.	1. Revised Appeals and Grievance (AGD) Beneficiary Grievance Management System policy and procedure (P&P) and workflows to ensure QOC cases meeting criteria are referred to the MD for resolution. 2. Revised AGD workflow for non-clinical and clinical staff to ensure QOCs are assessed, reviewed and resolved by a licensed health-care professional. 3. Revised staff desk level procedures and workflows to ensure resolution letters include Medical Director grievance review/rationale. 4. Trained clinical AGD staff on requirements for QOC grievance review process, clinical documentation of clinical findings and creation of recommendation to the MD.	1a. P&P_10.19.5 Beneficiary_Grievanc e_Management_Syst em 1b. Clinical Medi-Cal Oversight Grievance Triage Guideline_2081 1c. Clinical Medi-Cal Oversight QOC Grievance Review Guideline_2080 2a. Blue Shield Promise_QOC Grievance and Escalation Process_MHK 2b. Clinical Medi-Cal Oversight Grievance Triage Guideline_2081 2c. Clinical Medi-Cal Oversight QOC Grievance Review Guideline_2080 2d. AGD End-to-	1a. Completed by 6/30/2022 1b. Completed by 7/26/2022 1c. Completed by 7/26/2022 2a. Completed by 7/14/2022 2b. Completed by 7/26/2022 2c. Completed by 7/26/2022 2d. Completed by 8/1/2022 3a. Completed by 7/14/2022 3b. Completed by 6/30/2022 4. Completed by 5/20/2022 5. Completed by 4/20/2022 6. Completed by 4/20/2022	The following documentation supports the MCP's efforts to correct this finding: **Policies & Procedures:** • Updated P&P, "10.19.5, "Beneficiary Grievance Management System" (02/18/22) updated to include that all QOC and exempt grievances must be referred/reviewed by a Medical Director. • Desk Level Procedures, "Blue Shield Promise Quality of Care (QOC) Grievance and Escalation Process" (07/14/22) which guides the Grievance Coordinators, Clinical Oversight Nurses, and A&G Medical Director to ensure all QOC grievances are referred to the Medical Director. **Monitoring & Oversight** • Audits, "Clinical Audits" to be completed by 10/31/22. These clinical audits will ensure referral of all QOC grievances to its Medical Director. In addition, per the MCP's written response. The Operations team is conducting QA activities on a daily basis to ensure that member grievances are being handled appropriately and going through the right channels of resolution. The CMO/MD are participating in monthly grievance log reviews and pre-committee prep and committee meetings to review key AGD analysis, risks and trends being presented at various internal committees. • Scorecard, "Clinical AGD Scorecard" (11/2022) these monthly audits performed utilize a review of up to five cases per clinical staff member. Monitoring measures include key elements of the grievance process as

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	5. Revised monitoring process to ensure official documentation process for all MD meeting minutes involving oversight activity of the grievance process. 6. Revised existing workflow for MD review of grievance activity log including documentation of key elements demonstrating oversight of clinical issues and the appropriate grievance categorizations. 7. Create a grievance audit tool to evaluate consistency and ensure that Clinical Oversight is incorporated on the grievance process	End Process Flow 3a. Blue Shield Promise_QOC Grievance and Escalation Process_MHK 3b. Training AGD MD 4. Management of Quality-of-Care Grievances Training 5. Grievance Log Audit Steps 6. Grievance Log Audit Steps 7a. AGD Over_Monitor Program_clinical Scorecard 7b. MD Oversight 7c. Nurse	7a. Completed by 9/30/2022 7b. Completed by 12/15/2022 7c. Completed by 12/15/2022 7d. Completed by 12/15/2022 7e. Completed by 12/15/2022 7f. Completed by 12/15/2022	well as new processes recently developed needing monitoring to ensure staff adherence. Outcomes of the oversight and monitoring program will be reported to the AGD leadership. Final outcomes will be reported to the appropriate Quality Committees. Standard Medi-Cal AGD and Definitions Document – Intake Medi-Cal AGD" (11/2022) which ensures the MCP is monitoring all QOC cases for immediate referral to the Medical Director. • Monitoring Process, "Monitoring QOC cases for immediate referral to the Medical Director for resolution within the contractual timeframe" (10/22) the MCP has added a new Key Performance Indicator (KPI) which monitors monthly all QOC grievances are immediately referred to the AGD Medical Director for resolution. This KPI will be reviewed by Appeal and Grievances Leadership on a weekly basis. • KPI Report Results, "Compliance Processing of QOC Grievances" (11/2022) out of 68 QOC grievances reviewed all 68 were immediately referred to the Medical Director. Out of 44 QOC standard grievances reviewed all 44 were immediately referred to the Medical Director. • Audit Tools, "Definitions Document - Standard Medi-Cal AGD and Definitions Document – Intake Medi-Cal AGD" (11/2022) which ensures the MCP is monitoring QOC cases for immediate referral to the Medical Director. • Flowchart, "Clinical Medical Oversight Grievance Triage Guideline" (08/02/22) as evidence that the Plan has a process to ensure QOC grievances are referred to the Medical Director for review.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
		Oversight_Appeals 7d. Nurse Oversight_Grievances 7e. Nurse_AGD Scorecard_Appeal 7f. Nurse_AGD Scorecard_Grievances		• Process, “Blue Shield Promise Quality of Care Grievance and Escalation Process” (07/14/22) which describes the process for grievance coordinators, clinical oversight nurses and appeals & grievance Medical Director of referring QOC grievances to the Medical Director. **Training:** • PowerPoint Training, “Appeals and Grievances Department, Medical Director Role and Responsibilities” (06/29/22) ensures the Medical Director is responsible for the investigation and resolution of the QOC issues. • PowerPoint Training, “Clinical Oversight Team, Management of Quality-of-Care Grievances” (05/04/22) ensures how to properly document and refer for clinical decision making by the Appeals and Grievance Medical Director. • PowerPoint Training, “Grievance Definitions, Categorization Types, and De-Escalation Workflow” (03/22) and the attestation log of attendees. This PowerPoint was presented to grievance coordinators to ensure classification of QOS vs QOC grievances are classified correctly. **The Corrective Action Plan for finding 4.1.1 is accepted.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
4.1.2 Resolution of Grievances Involving Clinical Issues The Plan did not immediately refer all QOC grievances to the Plan's Medical Director for resolution within the contractual timeframe.	1. Revised the Appeals and Grievances Department (AGD) Policy and Procedure (P&P), titled, Beneficiary Grievance Management System, language to ensure Quality of Care (QOC) Grievances are referred to the Medical Director for resolution. Enhanced definitions for grievances as defined by regulatory and accreditation requirements. Conducted training on grievance definitions and categorizations to educate staff on differences between processing of QOCs and PQIs. 2. Revised AGD desk-level procedures (DLPs) to ensure appropriate closure activities for QOC grievances reviewed and resolved by the Medical Director (MD) for resolution within the appropriate timeframe based on the grievance type (72 hours/30 calendar days).	1a. P&P_10.19.5 Beneficiary Grievance Management System 1b. DLP_ Blue Shield Promise Standard Medi-Cal Grievance 1c. Grievance Definition Categorization and de-escalation Training 1d. Grievance Definitions Meeting attendees 1e. AGD Grievance Definition attendees 1f. Blue Shield Promise_Quality of Care (QOC) Grievance and Escalation Process_MHK	1a. Completed by 6/9/2022 1b. Completed by 4/27/2022 1c. Completed by 3/25/2022 1d. Completed by 3/25/2022 1e. Completed by 3/25/2022 1f. Completed by 07/14/2022 2a. Completed by 4/27/2022 2b. Completed by 5/25/2022 2c. Completed by 07/14/2022 3a. Completed by 7/18/2022 3b. Completed by 4/27/2022 3c. Completed by 5/25/2022 3d. Completed by 7/14/2022 4a & 4b.	The following documentation supports the MCP's efforts to correct this finding: **Policies & Procedures**: • Updated P&P, "10.19.5, "Beneficiary Grievance Management System" (02/18/22) updated to include that if a PQI includes both PQI and QOC grievance, the PQI will be reviewed and investigated by the Clinic Quality Review Department (CQR) and the grievance will be reviewed and investigated by the Appeal and Grievance Department (AGD). Also noted, all QOC grievances must be reviewed by a Medical Director. • Revised Desk Level Procedure, "Blue Shield Promise Medi-Cal Standard Grievances MHK" (04/27/22) as evidence the Grievance Coordinators have been provided guidance on how to process a Medi-Cal standard grievance with Blue Shield and the requirement of referring the QOC grievance to the Medical Director for review and resolution. • Desk Level Procedure, "Blue Shield Promise Quality of Care Grievance and Escalation Process" (Original date and effective date 07/14/22) provides the Grievance Coordinators, Clinical Oversight Nurses, and the A&G Medical Director with clinical oversight in regard to the steps to work the clinical standard grievance cases. The Medical Director will ensure if there is sufficient information to resolve the clinical grievance. • Revised Desk Level Procedure, "Blue Shield Promise – Intake Process" (07/18/22) which provides guidance for the intake coordinators on handling and assigning appeals or grievances received within Blue

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	3. Reviewed and revised the AGD DLPs for Operations and Clinical Oversight Teams to refer all QOC grievances to MD for final determination. 4. Developed focused training and re-trained AGD staff on the role of Clinical Oversight Team/ Nurses and AGD Coordinators on workflow changes to ensure grievances identified as QOC with clinical issues are investigated and referred to the MD for final determination. 5. Developed training for Clinical Oversight Team (Nurses) and Medical Directors on investigation, documentation, and resolution of grievances. 6. Revised workflow on documentation of final drafts of resolution letters to include MD grievance review/rationale.	2a. DLP_ Blue Shield Promise Standard Medi-Cal Grievance 2b. Blue Shield Promise Expedited Medi-Cal Grievance 2c. Blue Shield Promise_Quality of Care (QOC) Grievance and Escalation Process_MHK.pdf 3a. Blue Shield Promise_Intake Process_MHK 3b. Blue Shield Promise Standard Medi-Cal Grievance 3c. Blue Shield Promise Expedited Medi-Cal Grievance 3d. Blue Shield Promise_Quality of Care (QOC)	Completed by 5/4/2022 5a & 5b.Completed by 5/4/2022 6. Completed by 07/14/2022	Shield & AG Department. **Monitoring & Oversight** • Monitoring Process, “Monitoring QOC cases for immediate referral to the Medical Director for resolution within the contractual timeframe” (10/22) the MCP has added a new Key Performance Indicator (KPI) which monitors monthly that all QOC grievances are immediate referred to the AGD Medical Director for resolution. This KPI will be reviewed by Appeal and Grievances Leadership on a weekly basis. • KPI Report Results, “Compliance Processing of QOC Grievances” (11/2022) out of 68 QOC grievances reviewed all 68 were immediately referred to the Medical Director. Out of 44 QOC standard grievances reviewed all 44 were immediately referred to the Medical Director. • Audit Tools, “Definitions Document - Standard Medi-Cal AGD and Definitions Document – Intake Medi-Cal AGD” (11/2022) which ensures the MCP is monitoring QOC cases for immediate referral to the Medical Director. • Instructions, “Blue Shield Promise Medi-Cal Inventory Monitoring” (09/13/22) this document provides instructions for the Medi-Cal Inventory Monitoring process. Supervisors and Leads monitor Medi-Cal inventory daily by completing oversight and monitoring of QOC grievances to ensure QOC grievances are immediately referred to the AGD Medical Director for resolution. **Training**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
		Grievance and Escalation Process_MHK 4a. Management of Quality-of-Care Grievances Training 4b. Management of Quality-of-Care Grievances Training Attendees 5a. Management of Quality-of-Care Grievances Training 5b. Management of Quality-of-Care Grievances Training Attendees 6.Blue Shield Promise_Quality of Care (QOC) Grievance and Escalation Process_MHK.p		• PowerPoint Training, “Grievance Definitions, Categorization Types and De-Escalation Workflow” and list of participants (03/25/22) which provides AG staff the ability to identify grievances, grievance types (PQI vs QOC), and grievance categories. **The Corrective Action Plan for finding 4.1.2 is accepted.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
		df		
4.3.1 Privacy Breach and Notifying Required Entities The Plan did not provide notifications and DHCS PIRs to DHCS entities within the required timeframes.	1. Revised staff Job Aid procedure titled Job Aid 002A Promise Incident Response Reference Guide, to ensure timely notifications to all required DHCS personnel. 2. Conducted training and emailed staff reminders of updated DHCS notification procedures. 3. Updated the Privacy Office case tracker log to include required notification dates for incident reporting as well as built-in due date formulas. Daily monitoring will occur.	1. Job Aid 002A Promise Incident Response Reference Guide 2a. May 6, 2022, Privacy Office DHCS Training 2b. June 27, 2022, Privacy Office DHCS Email 2c. July 7, 2022, Privacy Office Case Tracker Email 2d. July 7, 2022, Privacy Office DHCS Email 2e. July 19, 2022, Privacy Office DHCS Email	1. Completed 6/27/2022 2a. Completed by 5/6/2022 2b. Completed by 6/27/2022 2c. Completed by 7/7/2022 2d. Completed 7/7/2022 2e. Completed 7/19/2022 3. Completed by 7/7/2022	The following documentation supports the MCP's efforts to correct this finding: **Training** • Revised Job Aid 002A directs staff to send reports to all three required DHCS personnel through the DHCS breach reporting portal within the required timeframes. • Privacy Office Training, Case Tracker and Privacy Office Emails demonstrate the MCP has trained its staff on the updated DHCS notification procedures. **Monitoring & Oversight** • Privacy Office Case tracker was updated to include the required notification dates with due date formulas. The tracker is monitored on a daily basis. **The Corrective Action Plan for Finding 4.3.1 is accepted.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
		3. Promise log of Reported Cases_SAMPLE		
5.3.1 New Provider Training The Plan did not ensure that all providers received training from the Plan or its delegated entities within ten-working-days after the Plan placed a newly contracted provider on active status.	1a. Developed and implemented resource tool to show delegates delegated for New Provider Orientation (NPO), also known as New Provider Training. 1b. Educate staff on use of new resource tool, to identify provider groups that are not delegated for NPO. 2a. Develop policy and implemented process for no providers to be entered into the Provider Information Management System as a Medi-Cal provider, without a training date. 2b. Issue CAPs to all delegates with non-compliant cases in universe.	1a.BSC_BSCPHP Delegate Vendor Matrix 1b. BSC Delegate Vendor Matrix Communication 2a.1.70.5.1.3 Provider Orientation and Education 2a.2 70.30.1 Delegation Operations Corrective Action-Escalation Process 2a.3. NPO PIMS Load Requirement	1a & 1b. Completed by 5/11/2022 2a. Completed by 9/8/2021 2b. Completed by 12/31/2021 3a & 3b. Completed by 3/29/2022 4a-4d. Completed by 6/8/2022	The following documentation supports the MCP's efforts to correct this finding: **Policies & Procedures** • Updated P&P, "70.5.1.4: Provider Orientation and Education" which states that New Provider Orientation (NPO) training completion is a requirement to add providers to the Medi-Cal network (2a.1 70.5.1.3 Provider Orientation and Education, Page 3). • Desktop Procedure, "Medi-Cal Orientation Training and Attestation" which states that when the Orientation completion and attestation date is not provided and is required per Medi-Cal relationship. (2a.3 NPO PIMS Load Requirement SOP, Page 4) • Updated P&P, "70.5.1.4: Provider Orientation and Education" (February 2022) in which New Provider Orientation (NPO) training completion is a requirement to add providers to the Medi-Cal network (2a.1 70.5.1.3 Provider Orientation and Education, Page 3). • Updated P&P, "70.30.1: Delegation Operations Corrective Action/Escalation Process" (07/19/22) in which all delegated entities are audited annually via virtual desktop audits. Audit results and

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	3. Develop and implement system enhancements to improve internal communication regarding providers without NPO completion dates. 4. Implemented enhancements to oversight process for vendors, including a corrective action escalation process for non-compliant vendors	SOP 2a.4. Network Business Rules 2a.5. IPA Matrix 2a.6 Medi-Cal Orientation Training Attestation Processor Roll-Out 2b.1 Sample CAP Exhibit E - Community Care IPA LLC CAP 2b.2 Sample CAP Exhibit D - Health Excel IPA Termination Notice 3a. Medi-Cal Orientation Training Attestation Reminder in Task Communications (CE Alert).pdf		scores are reviewed to determine necessary actions and follow up. These actions may include corrective action plans, enforcement actions, sanctions, or de-delegation (2a.1 70.5.1.3 Provider Orientation and Education, Page 3). • Workflow Chart, "Newly Contracted Provider Training" (02/11/22) which includes a process to verify if a training date is present. If no training date is present, then a task is opened for Provider Relations to obtain the training date (3b. New Provider Training Enhancements Process Map, Page 1). • Updated P&P, "10.30.4.1: Oversight of Specialty Health Plans/Vendors Specialty Health Plan/Vendor Contracted Provider Orientation and Education (New and Ongoing)" (05/25/22) in which the MCP has an Escalation Process. If the Specialty Health Plans/Vendors remains non-compliant after two CAPs/reports or two non-compliant quarterly audits have been demonstrated and or has not responded to the request for a CAP, the Specialty Health Plans/Vendors will be reported to the Delegation Oversight Committee (DOC) by Delegation Operations Management. If the Specialty Health Plans/Vendors disputes or refuses to correct the deficiency, Delegation Operations Management will notify the DOC to obtain a committee recommendation (4a. 10.30.4.1 Delegation Oversight Vendor Newly Contracted Provider Training, Page 5). • Letter Communication to Vendors, "Newly Contracted Provider Training Submission Updates (Specialty Health Plan/Vendors)" (06/08/22) as evidence that the MCP has sent a letter to their vendors regarding the changes effective immediately for newly contracted provider training submissions:

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
		3b. New Provider Training Enhancements Process Map 4a. 10.30.4.1 Oversight of Specialty Health Plans/Vendors Specialty Health Plan/Vendor Contracted Provider Orientation and Education (New and Ongoing) 4b. 70.30.1 Delegation Operations Corrective Action-Escalation Process 4c. Newly Contracted Provider Training Specialty Vendor Implementation 4d. Vendor		• A universe report of all newly contracted providers for the Medi-Cal line of business that were hired/contracted from the previous month must be submitted to Blue Shield Promise Health Plan monthly. • All monthly submissions must include completed and signed attestations for each of the newly contracted providers listed on the universe report. • Universe reports and accompanying attestations must be submitted to BSCPHP by the 15th of the following month. • If no new providers were added from the previous month a "No New Provider Attestation" needs to be completed and submitted to BSCPHP by the 15th of the following month. (BSCPHP Medi-Cal Newly Contracted Provider Training Notice 06.08.22) • Excel Spreadsheet, "Medi-Cal Vendor Universe Template" which has been revised by the MCP to account for the online provider directory portal/website upload date. The upload date will now be considered the provider's start date effective in the Vendor's network for the Promise members to access. The Vendor's monthly report submission must also include a completed and signed NCPT attestations for each newly contracted provider listed in the universe report (BSCPHP_MCL_ Newly Contracted Provider Training Universe_SpecialtyHP Vendor). • "Medi-Cal Contract Provider Training Corrective Action Plan (CAP)" (07/21/22) as evidence that the MCP has issued a CAP to their

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
		Meetings		delegated entity for failure to submit either a completed No New Provider Attestation or its Quarter 2 Newly Contracted Providers Training Universe Reports and completed Newly Contracted Providers Attestations for Quarter 2, 2022 (2022_BSCPHP_MCL_Newly Contracted Provider Training_CAP Form). **Training** • "Medi-Cal Orientation Training Attestation Reminder in Task Communications" in which effective September 1, 2021, a new check for a Medi-Cal Orientation Training Attestation became a requirement prior to adding a practitioner to a new Medi-Cal relationship. The MCP's vendor will begin adding the following verbiage to every task triaged: ○ "PROCESSOR: REMINDER TO CHECK FOR MCAL NETWORKS." This reminder is to check if the Medi-Cal Orientation Training Attestation will be required for the task that the MCP staff will work (3a. Medi-Cal Orientation Training Attestation Reminder in Task Communications (CE Alert)). • Meeting Invitations, "American Specialty Health (05/31/22), Vision Service Plan (06/06/22), Beacon Health Options (06/08/22)" as evidence that the MCP's Delegation Oversight Compliance Team conducted individual meetings during the 2nd Quarter 2022 with the Vendors informing them of the changes that will take place for current NCPT processes (4d. Vendor Meetings). • An email to MCP staff (05/11/22) to educate staff on use of new resource tool, to identify provider groups that are not delegated for NPO (1b. BSC

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				Delegate Vendor Matrix Communication). • Training Invitation, “Medi-Cal Orientation Training Attestation Date – Processor Roll Out” (08/31/21) as evidence that MCP staff were educated on capturing the Medi-Cal Orientation Training Attestation date in the Provider Information Management System (PIMS) (2a.6 Medi-Cal Orientation Training Attestation Processor Roll-Out). **Monitoring & Oversight** • “BSC_BSCPHP Delegate Vendor Matrix” which lists the delegates that are delegated for New Provider Training. The Delegate Vendor Matrix tracks the completion of New Provider Training for each delegate (1a. BSC_BSCPHP Delegate Vendor Matrix). • Sample, “Corrective Action” (11/15/21) as evidence that the MCP has issued a CAP to the delegated entity. The delegated entity has directed their providers to complete the Newly Contracted Provider Training and to obtain missing provider attestations (2b.1 Sample CAP Exhibit E - CAP). • Sample, “Termination Notice” (06/31/21) as evidence that the MCP has issued a Notice of Termination to the delegated entity (2b.2 Sample CAP Exhibit D - Termination Notice). **The Corrective Action Plan for Finding 5.3.1 is accepted.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments

Submitted by: Kristen Cerf **[Signature on file]**
Title: Promise Health Plan CEO & President

Date: August 15, 2022