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 Cal MediConnect Audit

Dear Ms. Cerf:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Cal MediConnect Audit of Blue Shield of California Promise Health Plan, a Medicare-Medicaid Plan (MMP), 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 MMP's submitted Corrective Action Plan (CAP). The CAP is hereby closed. The enclosed documents will serve as DHCS' final response to the MMP's CAP. Closure of this CAP does not halt any other processes in place between DHCS and the MMP 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
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Department of Health Care Services

Anthony Martinez, Lead Analyst
CAP Compliance Unit
Managed Care Quality and Monitoring Division
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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: Cal MediConnect Audit **Onsite Review: 01/18/22 – 01/27/22**

MMPs 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. MMPs 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 MMP shall directly address each deficiency component by completing the following columns provided for MMP response: 1. Deficiency Number and Finding, 2. Action Taken, 3. Implementation Documentation, and 4. Completion/Expected Completion Date. The MMP 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 MMP 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 MMP 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 MMP 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 MMP’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 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* (*Short-Term, Long-Term)	DHCS Comments
1. Utilization Management				
1.3.1 Expedited Appeals 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_Grievance_Management_System 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	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 5c. Completed by 10/31/2022 5d. Completed	The following documentation supports the MMP'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 that 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.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	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.	Expedited Request Review Guideline_2082 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	by 10/31/2022 5e. Completed by 10/31/2022 6a. Completed by 8/31/2022 6b. Completed by 8/31/2022	• If the appeal is for a clinically urgent situation, the coordinator will 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 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 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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		Audit- Error Report August 2022 5c. MCS Clinical Appeal Audit- Quality Detail Report August 2022 5d. Sample_AGD Clinical Scorecards 6a. Sample Pre-Committee Meeting Minutes 6b. Sample Committee deck		• Revised QA 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 Scorecards **The Corrective Action Plan for Finding 1.3.1 is accepted.**
1.3.2 Notice of Appeal Resolution Letters for Overturned Appeals The Plan's Notice	1. Developed a standardized template formatted for documentation of clinical decision making. 2. Developed training for	1. AGD_MD Template 2a. AGD_MD Training Material s 2b.	1.Completed by 7/15/2022 2a. Completed by 7/22/2022 2b. Completed by 6/29/2022	The following documentation supports the MMP's efforts to correct this finding: **Policies & Procedures** • Policy 10.19.5 (2/18/22) was revised to include the following: For overturned decisions, appeals resolved in favor of the

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of Appeal Resolution letters did not contain the reason why the decisions were overturned.	documentation requirements for overturn determinations, including all the elements noted in APL 21-011, and use of DHCS letter templates to ensure resolution letters include reason for overturns. 3. Reviewed and revised the existing oversight and monitoring Quality Assurance (QA) review process to include assessment of the presence of clinical documentation for all overturned appeals. Discuss these cases in the monthly grievance log monitoring meeting with the appropriate Medical Director.	Clinical Letter Writing Refresher Training Email 3a.Grievance Log Audit Steps 3b. Blue Shield Promise_Medi-Cal Inventory Monitoring_MHK is a DLP on QA process.	3a. Completed by 4/20/2022 3b. Completed by 9/30/2022	member, written notice to the member shall include the results of the resolution and the date is completed. The written response shall contain a clear and concise explanation of the reason, including the reason for why the decision was overturned. Blue Shield Promise shall use the DHCS template packet for appeals, which contains the NAR for overturned decisions. • Desktop Procedure: AGD Standardized Documentation Template (Review/Notification) Requirements Outlines requirements for clinical assessment • Was the initial denial appropriate • Is there additional documentation relevant for reconsideration • Does the case need an external physician review Clinical Recommendation – document final determination. • Uphold determination based on medical necessity or not a covered benefit • Overturn initial determination and approve member request Appeal resolution letter requirements resolved in the member's favor, a clear and concise explanation of why decision was overturned. Results of resolution process/date completed. **Training** • Medical Director Roles and Responsibilities training provides an entire overview of the grievance and appeal process and

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				resolution letter narrative requirements, including upholds and overturns. Training addresses overturn resolution letters require a clear and concise explanation of why the decision was overturned and provides example narrative language to use. • Email: Overturn appeals decisions reminder. Email reminder was in direct response to the audit finding. It served to remind clinical staff to ensure that clinical rationale is clearly documented in system and transferred correctly to member overturn letters. The clinical rationale must be clearly documented in MHK and transferred correctly to member overturn letters. Medi-Cal coordinators that need additional clarification on any clinical rationale for overturn letters, can reach out to the leadership staff and work with the MD/Nurse to answer any questions or updates to system information reflects the correct information. **Monitoring & Oversight** • The Plan updated its Grievance Log audit to include a review of overturned appeals. • The Plan incorporated a review of Overturned and Upheld Appeal as part of its monthly grievance log review process. The grievance log is used to select cases for review on a monthly basis. Cases are selected by type: QOS, QOC, Overturn Appeals, Upheld Appeals. Cases selected for the monthly audit are reviewed for appropriate resolution, including

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				addressing all concerns and appropriateness of overturn and upheld decisions. During the monthly Grievance Log audit meetings, audit findings are discussed, and remediation plans are established if issues/trends are identified. • Inventory Monitoring Process. The Plan has established processes to monitor Medi-Cal inventory daily through the following: Checking MHK Dashboard throughout the day for volume and case status. Checking the intake queue throughout the day for receipt status of expedited and downgraded cases. **The Corrective Action Plan for Finding 1.3.2 is accepted.**
1.3.3 Member's Written Consent for Appeals Filed by a Provider The Plan did not obtain written consent from a member when a provider filed an appeal on the member's behalf.	1. Revised Appeals and Grievances (AGD) Policy and Procedure (P&P), titled, Beneficiary Grievance Management System, to require written consent from a member when a provider files an appeal on behalf of the member. 2. Update Desk Level	1. P&P_10.19.5 Beneficiary Grievance Management System 2a. Blue Shield Promise_CMC	1. Completed by 6/09/2022 2a. Completed by 2b. Completed by 2c. Completed by 3. Completed by 9/1/2022	The following documentation supports the MMP's efforts to correct this finding: **Policies & Procedures** • Policy 10.19.5- Beneficiary Grievance Management System. Plan submitted revised policy, which includes the required language indicating appeals files by a provider on behalf of a member require written consent from the member. The Plan removed the language that did not apply to Cal MediConnect or Medi-Cal. Plan submitted revised desktop procedures relating to Standard Appeals, Expedited Appeals that indicates

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	Procedures (DLPs) to define the process that requires written consent from a member when providers files an appeal on behalf of the member. 3. Review and revise the grievance and appeal oversight and monitoring, Quality Assurance (QA) review to assess, prior to case closure, when a provider is filing on behalf of a member that there is consent from the member in the file. 4. Train the team on the requirement to obtain written consent when a provider files an appeal on behalf of the member.	Expedited Appeals_MHK 2b. Blue Shield Promise_CMC Standard Grievances _MHK 2c. Blue Shield Promise_CMC Appointment of Representative (AOR) Requests_MHK 3. Blue Shield Promise_Medi-Cal Inventory Monitoring_MHK 4a. Written	4a. Completed by 8/17/2022 4b. Completed by 8/17/2022	appeals filed on behalf of a member requires an AOR or written equivalent from the member that they give permission. • DTP - Appointment of Representation Requests outlines the process for handling appeals and grievances received from someone other than the member. Requires written consent to proceed with review of an appeal when received on behalf of the enrollee by a prescribing physician or other prescriber acting on behalf of the enrollee, or staff of a physician's office acting on a physician's behalf. Appeals filed by the provider, on behalf of the member, require written consent from the member. Outlines procedures to verify if an AOR is on file or is needed. Without an AOR from the member, the Plan intake coordinator will call the member and ask them to either file their own appeal or submit in writing that the requesting provider can file an appeal on their behalf. Plan is required to attempt and document three-member outreach attempts. **Training** Plan provided training materials – Written Consent of Provider Appeal on Behalf of a Member, which included the following: • Discussion of audit finding and applicable APL requirements. • Need for AOR or a written permission for provider to file on the member's behalf. • Documentation to be included with appeal request or on file in the Plan's system. Process includes member outreach:

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		Consent of Provider Appeal on behalf of Member (CMC)_ 4b. Attendee List 8.17.22		If a provider files an appeal, the member is called to request that they file an appeal directly or submit in writing evidence of permission/consent. The Plan will make three documented attempts to contact the member to obtain consent in writing from the member or for the member to submit a member initiated oral appeal. After three documented attempts, an AOR letter is mailed to the member. The case is not worked until AOR form is obtained. **Monitoring & Oversight** Supervisors and leads monitor Medi-Cal Inventory daily. Tasks include the following: Determine if written consent from the member is on file. Verify member outreach by ensuring intake made three documented attempts. Confirm AOR acknowledgement letter was sent. Sample AOR Request template letter which is sent to members to obtain the required written consent to process an appeal filed on behalf of the member. **The Corrective Action Plan for Finding 1.3.3 is accepted.**
2. Case Management and Coordination of Care				

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
2.1.1 Health Risk Assessment The Plan did not ensure the provision of a HRA to each member within the required timeframes.	1. Development of Prospective Audit Tool (PAT) to identify members who require an HRA within the required timeframe based on the DPL 17-001 (HRA outreach to be completed within 45 days for high risk and 90 days for low risk). This automated tool is used to ensure HRA outreach is completed within the required timeframe 2. Weekly PAT review meetings with HRA Vendor Team and Care Management Team. Meeting to review approaching HRA deadlines and to ensure that outreach is completed timely. (45 days for high risk and 90 days for low risk). 3. Re-train HRA Vendor on the regulatory requirements of DPL 17-001 (HRA outreach to be completed	1.PAT_IN-COMPLIANT_05022022_CMC 2. BSC HRASameSky PAT Weekly Review Meeting 3a. Cal MediConnect HRA ICP Training_SameS ky 3b. CMC HRA Training Attendee List-4.20.22 3c. CMC HRA Training Attendee List-4.28.22	1.Completed by 10/01/2021 2. Completed by 04/15/2022 3.Completed by 04/30/2022 4.Completed by 04/30/2022 5.Completed by 04/14/2022	The following documentation supports the MMP's efforts to correct this finding: **Monitoring & Oversight** • Prospective Aid Tool used to identify members who require HRA and ensure outreach is completed in the required timeframe. • Meeting notice for weekly review of PAT demonstrates the MMP's Management and HRA Vendor Team meet regularly to review approaching HRA deadlines. • CMC HRA ICP Training from 4/2/22 and Training Attendee Lists demonstrates the MMP trained the Vendor on the regulatory requirements for HRA timeframes as well as the weekly review of the PAT. **Policy & Procedures** • Updated HRA Vendor Oversight Policy outlines the responsibilities of the MMP's Care Management Department for overseeing delegated functions of HRA operations. **Training** • Cal MediConnect HRA ICP Training and Attendance Logs for internal staff demonstrates the MMP's internal staff was trained on HRA regulatory requirements.

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	within 45 days for high risk and 90 days for low risk). 4. Modified HRA Vendor oversight management P&P. 5. Re-Train all front-line BSC Promise staff (Clinical Service Coordinators (CSCs) and Care Managers (CMs)) on the regulatory requirements of DPL 17-001 (HRA outreach to be completed within 45 days for high risk and 90 days for low risk).	4. 70.4.5 HRA Vendor Oversight Management _FINAL 5a. Cal MediConnect HRA ICP Training 5b. CM CMC HRA_ICP Internal Staff Training Attestation 04 14 2022 5c. CSC CMC HRA_ICP Internal Staff Training_ Attestation 04 14 2022		**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
2.1.2 Individualized Care Plan The Plan did not develop an ICP for each new member within 90-calendar- days of enrollment.	1. Development of Prospective Audit Tool (PAT) to identify members who require an ICP within the required timeframe based on the DPL 17-001. This tool is used to ensure ICPs are done within the required timeframe. (ICP to be completed within 90 days of enrollment). 2. Twice Weekly PAT review meetings with Care Management Team to ensure timely completion of ICP within 90 days of enrollment 3. Re-Train all front-line BSC Promise staff (Clinical Service Coordinators (CSCs) and Care Managers (CMs)) on the regulatory requirements of DPL 17-001 (ICP to be completed within 90 days of enrollment). 4. Update Policy and Procedure to align with ICP requirements in DPL	1. Pat_IN-COMPLIANT_05022022_CMC 2. CMC PAT Tool Review 3a. Cal MediConnect HRA ICP Training 3b. CM CMC HRA_ICP Internal Staff Training Attestation 04 14 2022 3c. CSC CMC HRA_ICP Internal Staff Training_ Attestation 04 14 2022 4. 90.4.2	1. Completed by 10/01/2021 2. Completed by 10/01/2021 3. Completed by 04/14/2022 4. Completed by 03/31/2022	The following documentation supports the MMP's efforts to correct this finding: **Monitoring & Oversight** • Prospective Aid Tool used to ensure ICPs are done within the required timeframe. • Meeting notice for PAT Tool Review demonstrates the MMP's Clinical Service Coordinators (CSCs) and Care Managers (CMs)) meets twice weekly to review the PAT to ensure completion of ICPs within 90 days. **Training** • Cal MediConnect HRA ICP Training and Attendance Logs for internal staff demonstrates the MMP's internal staff was trained on requirement that ICPs must be completed within 90 days. **Policy & Procedures** • Policy 90.4.2 updated to require Initial ICP assessment to be completed within 90 days of initial enrollment into the plan. **The Corrective Action Plan for Finding 2.1.2 is accepted.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	17-1. Policy updated to have ICP completed within 90 days of enrollment.	Individual Care Plan_Final		
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 3 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	1. BSCPHP NEMT PCS 2a. Blue Shield Promise NEMT Proactive Outreach Process 2b. KB 072722_DN0034 9 – Transportation Authorization Expiration Outreach	1. Completed by 11/2022 2a. Completed by 7/12/2022 2b. 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 o The revised PCS/TAR form was reviewed & approved by MCOD. The form includes all necessary components to ensure

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	rides if PCS expires without renewal.			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: • BlueShield PCS/TAR Form o 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 o 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]

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				The Corrective Action Plan for finding 3.8.1 is accepted.
3.8.2 Treatment Authorization Request The Plan did not consistently require prior authorization 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 3 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	1. BSCPHP NEMT PCS 2a. Blue Shield Promise NEMT Proactive Outreach Process 2b. KB 072722_DN0034 9 – Transportation Authorization Expiration Outreach	1. Completed by 11/2022 2a. Completed by 7/12/2022 2b. 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 ○ 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] ○ 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 ○ 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.

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	rides if PCS expires without renewal.			**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
				  ○ 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]
				
				• BSCPHP_NEMT Proactive Outreach Process
				  ○ 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.
				
				• Transport Auth Exp Outreach

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				○ 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.**
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 Cal MediConnect members if the subcontractor is not successfully enrolled within 120 days of their initial application submissions to DHCS, unless they have	1a. Excerpt from Call the Car 80.6.8 Initial and Ongoing Credentialing of Subcontractor Providers 1b. Call the Car Subcontractor Enrollment Memo 2. 10.31.3 NMT NEMT Medi-	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 ○ 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]

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	an approved emergency enrollment application (crossover application) during the public health emergency (PHE). The Plan's provider is requiring its subcontractors with pending applications to send 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	Cal Enrollment Monitoring		**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 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.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	subcontractors with pending applications monthly to ensure they do not drive Cal MediConnect members after 120 days. The Plan will require immediate corrective action for any deficiencies identified.			

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

Date: August 15, 2022