DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

September 19, 2023

Robert Franco, Chief Compliance Officer
Gold Coast Health Plan
711 E. Daily Dr., Suite 106.
Camarillo, CA 93010

RE: Department of Health Care Services Medical Audit

Dear Mr. Franco:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Gold Coast Health Plan, a Managed Care Plan (MCP), from July 25, 2022 through August 5, 2022. The audit covered the period of June 1, 2021 through May 31, 2022.

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 audit report and final CAP remediation document (final Attachment A) 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]

Lyubov Poonka, Chief
Audit Monitoring Unit
Process Compliance Section
Managed Care Monitoring Branch
Managed Care Quality & Monitoring Division
California Department of Health Care Services

Enclosures: Attachment A (CAP Response Form)

cc: Maria Angel, Lead Analyst
Audit Monitoring Unit
Process Compliance Section
Managed Care Monitoring Branch
Managed Care Quality & Monitoring Division
California Department of Health Care Services

Lyubov Melnichuk, Contract Manager
Contract Compliance & Communications Unit
Managed Care Operations Division
California Department of Health Care Services

ATTACHMENT A
Corrective Action Plan Response Form

Plan: Gold Coast Health Plan (GCHP)

Review Period: 06/01/2021 - 05/31/2022

Audit Type: Medical Audit and State Supported Services

On-site Review: 07/25/2022 - 08/05/2022

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. Finding Number and Summary, 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.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
2. Case Management and Coordination of Care				
2.1.1 Blood Lead Screening Tests The Plan did not ensure the provision of BLS tests to child members at ages one and two.	1. Developed a provider-focused dedicated Pediatric Lead Screening webpage that includes lead screening resources from the CA Department of Public Health (CDPH) and Child Health and Disability Prevention Program (CHDP)	GCHP Pediatric Lead Screening Webpage.PDF https://www.goldcoasthealthplan.org/for-providers/provider-resources/pediatric-lead-screening/	Launched 10/20/2022 Communication mechanisms include: • Sharing at Quality Improvement (QI) Collaboration Meeting forums • 10/20/2022 Provider Email Update • Joint Operating Meetings (JOM)	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** - Updated P&P, "QI-029: Blood Lead Screening of Young Children" which demonstrates that the MCP's Care Management and Quality Improvement team coordinates and collaborates with the local California Lead Poisoning Prevention Program on members with elevated blood lead levels to provide additional support and resources for the MCP's members. On a monthly basis, the MCP will identify children with elevated blood lead levels. Once identified, they are referred to a care manager. A care manager will ensure that the child is receiving the appropriate follow up activities. The parent/guardian of the child is contacted to ensure that they are completing the recommended follow-up and provided other applicable resources. (Policy QI-029 Blood Lead Screening of Young Children_Redlined_Jan 2023). "Member Incentive Program – Approval Form" (05/08/23) to demonstrate that the MCP will create a member incentive program to increase the lead screening performance measure rate. A flyer will be mailed to members offering a gift card to get lead tests completed. (Lead Screening Member Incentive Program). **TRAINING**
	2. Created a Childhood Blood Lead Level Screenings Tip Sheet for provider offices to post in workstations and other areas for staff education	GCHP Lead Screening Tip Sheet.PDF	Implemented 10/04/2022. Distribution mechanisms include: • Posting to GCHP Pediatric Lead Screening Webpage • Sharing at QI Collaboration Meeting forums • Provider mailing planned in Q1-Q2 2023 • JOMs	

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	3. Distribution of quarterly gap reports via secure email to providers/clinic systems detailing assigned Members with missed blood lead screening tests between 0-12 months, 13-24 months and 25-72 months	LSC Gap Report Template_Jan2023.xlsx	Quarterly reports to providers were initiated in Q1 2021 and revamped in January 2023, based on provider feedback to make them more user-friendly.	- "GCHP Pediatric Lead Screening Webpage" which demonstrates information on protocols for lead testing and best practices to promote lead screening. (GCHP Pediatric Lead Screening Webpage). - "GCHP Lead Screening Tip Sheet" for distribution to provider offices which demonstrates a reminder to perform blood lead level testing on children at 12 months and 24 months of age. The tip sheet also reminds to document a parental refusal in the medical record including the signed refusal form along with best practices. (GCHP Lead Screening Tip Sheet). - "Lead Screening in Children (LSC) Gap Report Template" (January 2023) which demonstrates the quarterly email distribution of reports to providers/clinic systems detailing assigned members with missed blood lead screening tests between 0-12 months, 13-24 months and 25-72 months. (LSC Gap Report Template_Jan2023). - "CHDP Collaborative Meeting Agenda" (03/28/23) which demonstrates the MCP's ongoing quarterly collaboration meetings with the local Childhood Lead Poisoning Prevention program to discuss cases of elevated blood lead levels to ensure there are no gaps in services and to prevent duplication of services. (2.1.1 CHDP Meeting Minutes 03282023). **MONITORING AND OVERSIGHT**
	4. Implemented supplemental medical record review (MRR) process for auditing of records for BLS testing, documentation of anticipatory guidance, documentation of testing refusal, as applicable, and reason if test not performed, with feedback reports and education to providers on findings and opportunities for improvement. BLS testing and anticipatory guidance also reviewed in quarterly IHA MRRs and Facility Site Review (FSR) MRRs done every 3 years.	LSC MRR Tool Process.PDF LSC Focused MRR Tool_Jan 2023.xlsx IHA MRR Monitoring Report Q1_2022.PDF	BLS medical record review to be completed semi-annually in May and December each year. IHA MRR Resumed 8/30/22	

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	5. Collaborate with local Childhood Lead Poisoning Prevention Program and care management team to provide coordinated support and resources for plan Members with elevated blood lead levels.	Policy QI-029 Blood Lead Screening of Young Children_Redlined _Jan 2023.PDF	Initial meeting with Care Management and QI to discuss outreach plan for members with elevated BLLs on 1/11/2023. Next meeting with CLPPP and GCHP QI/CM 2/13/23. Anticipated launch in March 2023.	- "LSC Focused Medical Record Review Tool" (January 2023) which demonstrates the MCP's monitoring for lead screening in children. The MCP will review Lead Screening reports bi-annually in May and December. The review tool validates if the member had a well care exam at the time frame lead screening was due, written and/or oral anticipatory guidance, and whether a test was ordered and performed for 12 months, 24 months, or catch up 72 months. If there is no documentation of a blood lead screening, the RN reviewer verifies in the medical record if a lead screening refusal form or documentation of reason test was not ordered is in the chart. Lead Focused MRR findings are calculated, and scores less than 80% will result in a corrective action plan (CAP) that is sent to the provider which includes areas of deficiencies and action to be taken. (LSC MRR Tool Process) (LSC Focused MRR Tool_Jan 2023). - "Lead Screening in Children Focused Medical Audit Results" (May 2023) to demonstrate the MCP's audit results of monitoring for blood lead screening testing, documentation of anticipatory guidance, documentation of testing refusal, as applicable, and reason if test not performed. (2023_05_Lead Focused MRR Results). **The Corrective Action Plan for Finding 2.1.1 is accepted.**
	6. Build a Quality Incentive Program (QIP) for primary care providers with NCQA LSC as a core measure and explore an additional per-test provider incentive model.	Contracts under development. Planning meetings occurring with QI, Provider Network Operations, Chief Medical Officer (CMO), and legal counsel.	QIP slated to launch by Q3 2023.	
2.1.2 Anticipatory Guidance for Lead Exposure The Plan did not	1. Developed a provider-focused dedicated Pediatric Lead Screening webpage that contains lead screening resources from the CA DPH	GCHP Pediatric Lead Screening Webpage.PDF https://www.goldcoasthealthpl	Launched 10/20/2022 Communication mechanisms include: • Sharing at QI Collaboration	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES**

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ensure anticipatory guidance was provided to parents or guardians of age-appropriate members.	and CHDP	an.org/for-providers/provider-resources/pediatric-lead-screening/	Meeting forums • 10/20/2022 Provider Email Update • JOMs	- P&P, "QI-029: Blood Lead Screening of Young Children to demonstrate that the MCP's providers are required to provide oral or written anticipatory guidance to the parents or guardians of a child member during each PHA, about exposure to lead, and are at risk of lead poisoning from the time the child begins to crawl until 72 months of age. - "Refusal of Lead Testing Form" to demonstrate that the MCP created this form for providers to utilize with patients and place in the medical record. The lead screening form has been created as a tool for providers to use to document a refusal. If a test is not performed, a signed refusal must be included in the medical record. The form also includes anticipatory guidance. (GCHP Lead Poisoning Refusal Form). **TRAINING** - "GCHP Pediatric Lead Screening Webpage" which demonstrates information on protocols for lead testing and best practices to
	2. Created the Childhood Blood Lead Level Screenings Tip Sheet for provider offices to post in workstations	GCHP Lead Screening Tip Sheet.PDF	Implemented 10/04/2022 Distribution mechanisms include: • GCHP Pediatric Lead Screening Webpage • Sharing at QI Collaboration Meeting forums • Provider mailing planned in Q1-Q2 2023 • JOMs	

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	3. Implement supplemental medical record review (MRR) process for auditing of records for BLS testing, documentation of anticipatory guidance, documentation of testing refusal, as applicable, and reason if test not performed, with feedback reports and education to providers on findings and opportunities for improvement. BLS testing and anticipatory guidance also reviewed in quarterly IHA MRRs and FSR MRRs done every 3 years.	LSC MRR Tool Process.PDF LSC Focused MRR Tool_Jan 2023.xlsx IHA MRR Monitoring Report Q1_2022.PDF	BLS medical record review to be completed semi-annually in May and December each year. IHA MRR Resumed 8/30/22	promote lead screening. (GCHP Pediatric Lead Screening Webpage). - "GCHP Lead Screening Tip Sheet" for distribution to provider offices which demonstrates a reminder to perform blood lead level testing on children at 12 months and 24 months of age. The tip sheet also reminds to document a parental refusal in the medical record including the signed refusal form along with best practices. (GCHP Lead Screening Tip Sheet). - Provider Memorandum (October 2022) to demonstrate that the MCP provided a notice to their providers to attend a Lead Poisoning Prevention in Children online training. The MCP also introduced a Pediatric Lead Testing Toolkit which can be accessed online to help providers perform the recommended pediatric blood lead level testing. (Provider Update_Oct2022_blood-lead-provider-training). - "Blood Lead Screening in Children" (08/18/22) to demonstrate that the MCP provided training to providers regarding anticipatory guidance of lead exposure. (QI Collaboration Meeting Presentations_Minutes). **MONITORING AND OVERSIGHT** - "LSC Focused Medical Record Review Tool" (January 2023) which demonstrates the MCP's monitoring for lead screening in children. The MCP will review Lead Screening reports bi-annually in May and December. The review tool validates if the member had a well care exam at the time frame lead screening was due, written
	4. Created the GCHP Refusal of Lead Testing form for providers (that includes anticipatory guidance) to utilize with patients and place in the medical record.	GCHP Lead Poisoning Refusal Form.PDF	Implemented 9/15/2022 Distribution mechanisms include: • GCHP Pediatric Lead Screening Webpage • Sharing at QI Collaboration Meeting forums • Provider mailing planned in Q1-Q2 2023 • JOMs	

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	5. Provider education including training webinars, quarterly QI Collaboration Meetings for the full GCHP provider network, and monthly individual QI Collaboration meetings with contracted provider systems.	Provider Update_Oct2022_ blood-lead-provider-training QI Collaboration Meeting Presentations_Minutes.PDF GCHP QI_Clinic System Mtg Minutes-Lead Screening 2022	Training conducted 11/01/22 Provider QI Collaboration Meetings: 8/18/22,10/19/22 Individual QI Collaboration meetings 9/30/22; 10/4/22; 10/27/22; 11/14/22; 12/22/22	and/or oral anticipatory guidance, and whether a test was ordered and performed for 12 months, 24 months, or catch up 72 months. If there is no documentation of a blood lead screening, the RN reviewer verifies in the medical record if a lead screening refusal form or documentation of reason test was not ordered is in the chart. Lead Focused MRR findings are calculated, and scores less than 80% will result in a corrective action plan (CAP) that is sent to the provider which includes areas of deficiencies and action to be taken. (LSC MRR Tool Process) (LSC Focused MRR Tool_Jan 2023). - “Lead Screening in Children Focused Medical Audit Results” (May 2023) to demonstrate the MCP’s audit results of monitoring for blood lead screening testing, documentation of anticipatory guidance, documentation of testing refusal, as applicable, and reason if test not performed. (2023_05_Lead Focused MRR Results). **The Corrective Action Plan for Finding 2.1.2 is accepted.**
3. Access and Availability of Care				

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
3.8.1 Physician Certification Statement Form The Plan did not ensure NEMT providers use the required DHCS approved PCS form.	1. Conduct ongoing validation of transportation vendor authorization to verify that Members receiving NEMT have a valid NEMT authorization on file. • Obtain monthly NEMT reporting from transportation vendor. • Plan will review monthly NEMT file. • Obtain any needed PCS forms or updated forms as needed.	NEMT Monthly Data Log Template	Started on 2/15/2023 and NEMT validation process expected to be implemented by 4/1/2023	*The Plan identified that providers had copies of a previous version of PCS form. The Plan updated the website with the approved DHCS-approved PCS form May 2022.* The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** - Plan policy "HS-047 NEMT & NMT" demonstrates that providers are required to complete & submit the DHCS-approved PCS/authorization form prior to services being rendered. [IV. Procedure, D.3., page 2-3 - Requests for Non-Emergency Medical Transportation ○ The Non-Emergency Medical Transportation (NEMT) form was updated by the Plan in May 2022. **TRAINING** - Various provider training evidence the Plan is no longer accepting outdated NEMT forms. Providers were notified to preclude delays in processing NEMT requests to ensure the use of the updated form. If an outdated form is received, the requesting provider's office will be contacted to re-submit the request with newest form. The Plan notified providers via provider bulletin, new provider orientation & NEMT Updates meeting. **MONITORING AND OVERSIGHT** - Plan policy "HS-047 NEMT & NMT" demonstrates the Plan will
	2. Conduct Provider Education on usage of current PCS form. • Articles and communications to providers on PCS form and NEMT process. • Reinforce NEMT requirements and process during provider training and other on-site visits conducted to provider sites.	Provider Site Visit Form POB Article on "Requests for NEMT Transportation" Provider Update "Requests for NEMT"	Started on 2/1/2023 and expected to be completed by 3/15/2023	

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				perform monthly verification with the transportation vendor to ensure members receiving NEMT has a PCS form/Authorization Form on file and/or a form will be obtained for any member missing one. The Plan will impose corrective actions if any non-compliance is identified through its oversight & monitoring activities. [IV. Procedure, K.3. (b)(c), 4. Page 7] - Lack of Information (LOI) Process & Request for Information (RFI) Process Job Aid Manual (JAM) demonstrate remediation for incomplete or missing information. - Plan procedure "NEMT-NMT COA Process Job Aide Manual" demonstrates the Plan's daily monitoring process. If a request is made with an outdated form, the provider will be contacted to remediate non-compliance. [2. Processing NEMT Prescription/Attestation Forms, B. ii, Page 3] - The Plan's "NEMT Monthly Data Log Results" demonstrates the implemented procedures where the Plan gathers the requests daily & generates reports monthly from this log. **The Corrective Action Plan for Finding 3.8.1 is accepted.**
	3. Conduct internal Staff Training of UM staff on NEMT/NMT process	NEMT/NMT COA process Job Aid manual NEMT Process Updates Meeting and Attestation 2-15-2023	Completed on 2/15/2023	

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
3.8.2 Medi-Cal Enrollment of Transportation Providers The Plan did not ensure its transportation providers were enrolled in the Medi-Cal program.	1. Correct non-compliant subcontracting activities by transportation vendor for NEMT/NMT services • Issue corrective action plan to Vendor. • Require Vendor to update subcontracting policy to be compliant with DHCS and contractual requirements. • Perform ongoing meetings to review vendor action plans	Letter of non-compliance – VTS Subcontractors GCHP-VTS Meeting Notes	Letter of Non-Compliance and CAP issued on 7/22/2022 Ongoing meetings w/ Vendor Started on 11/10/2022 Implementation of updated Vendor Subcontracting Policy expected on 4/15/2023; monitoring of Vendor implementation of policy	The following documentation supports this finding: **POLICIES AND PROCEDURES** - Plan policy NO-013, *Screening and Enrollment of New Providers (revised 6/30/2020),* stated that when a provider is non-Medi-Cal certified, they are required to enroll in the Medi-Cal program and must submit a Provider Enrollment Agreement to DHCS. **MONITORING AND OVERSIGHT** -HS-047 NEMT & NMT Services ○ The Plan will monitor the contracted transportation broker for compliance with applicable federal & state laws, regulations, DCHS contract requirements, APLs & Policy Letters. This will also include monitoring the oversight of the transportation broker over their transportation subcontractors. ○ The Plan will conduct compliance monitoring activities of its contracted transportation broker on a regularly scheduled basis that occurs no less than on quarterly basis. The monitoring activities include verifying enrollment & credentialing of transportation providers including their oversight of subcontractors' enrollment. ○ The Plan will perform a monthly NEMT authorization verification with the transportation vendor that includes the broker providing a monthly NEMT transportation roster. ▪ The transportation provider roster "Gold Coast Roster" demonstrates all providers are enrolled, pending or have since been terminated. The Plan has received full approval of its Transportation Roster as of 08/28/2023.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				○ The Plan will impose corrective actions on the broker if any non-compliance is identified through its NEMT/NMT oversight & monitoring activities. ▪ "Broker Audit CAP Update" demonstrates the Plan implemented quarterly monitoring process to verify that the utilized transportation providers are enrolled in the Medi-Cal program. ▪ Since, the Plan issued a CAP to its broker. The Plan conducted a quarterly Driver Credentialing & Subcontracts Audit as part of its Delegation Oversight. The results of the audit were issued as part of the CAP imposed on the broker & the broker was required to respond & remediate the findings. **The Corrective Action Plan for Finding 3.8.2 is accepted.**
	2. Perform additional oversight activities over transportation vendor related to subcontractors. • Perform oversight audits of vendors credentialing activities, including vetting of subcontractors.	VTS Credentialing Pre-Audit Letter	Pre-audit letter issued on 11/10/2022 and expected audit to be completed by 4/1/2023 including the issuance of any corrective action plan resulting from the audit.	
5. Quality Management				

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
5.3.1 Provider Training The Plan did not ensure newly contracted providers received training within ten working days after placing providers on active status and did not complete the training within 30 calendar days.	1. Convened meetings with Provider Relations Representatives and Leads to review the provider training process. • Updated department internal Job Aid Manual to included updated processes. • Updated Provider Orientation Policy & Procedure to include the updated processes. • Updated Provider Orientation Tracking Log to document the Provider Orientation process. 2. Met with the Provider Network Operations team to provider overview of changes to the processes and policies	NO-001- Provider Orientations Provider Orientation Job Aid Manual Orientation Tracking Template	Started implementation on 1/28/2023 and completed on 2/9/2023 Shared updates on 2/9/2023 and expected to be completed by 2/23/2023	The following additional documentation supports the MCP's efforts to correct this finding: *The Plan met with Provider Relations Representatives and Leads to review processes and identify items that prevented successful completion of timely Provider Orientations (1/28/23)* *The Plan also discussed changes to the Provider Network Job Aid Manual (JAM) deliverable with the entire Provider Network Operations Team (2/13/23)* **POLICIES AND PROCEDURES** - NO-001: Provider Orientation P&P o The Plan submitted an updated P&P to include new procedures committing new providers to receive and complete training within 10 & 30 days, respectively, in addition to requiring earlier and more frequent follow-up on incomplete/non-responsive trainings progress. - Draft of Job Aid Manual (JAM) Orientation Tracking o The Plan updated this Provider Network Operations JAM to include updated Provider Orientation processes and monitoring & oversight which works in tandem with the Provider Orientation Tracking Log. **MONITORING AND OVERSIGHT** - NO-001: Provider Orientation P&P o Staff personnel initial follow-ups within three [3] business days instead of the prior 10 business days. o Until training is completed, staff conduct follow-up every

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				three [3] business days instead of the previous weekly rate. o Lastly, non-responsive providers are escalated to the Senior Director of Provider Network Operations no later than 15 days after active status. - Draft of Job Aid Manual (JAM) Orientation Tracking o The Plan submitted a JAM to help staff implement verifications, event-notifications, collect attestations, and work synchronously with the Orientation Tracking Log outlining follow-up and escalation procedures complete with reminders and verifications. o Leads and Management review the Orientation Tracking log weekly to ensure compliance with the New Provider Orientation process. - PR Orientation Training Log (March 2023) o The Plan provided a tracking log containing results for 25 providers in March 2023, tracking contract start dates, whether welcome letters were sent, post-30-day deadlines, follow-up dates, and completion. o If applicable, frequency and next follow-up dates were indicated for the post-30-day contract start date timeframe. **The Corrective Action Plan for Finding 5.3.1 is accepted.**

Submitted by (Plan: **Gold Coast Health Plan** **Date: 2/17/2023**
Title: **Robert Franco – Chief Compliance Officer**