DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

August 10, 2023

Mr. Michael Wood, Manager Regulatory Affairs & Compliance
CalOptima
505 City Parkway West.
Orange, CA 92868

RE: Department of Health Care Services Medical Audit

Dear Mr. Wood:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of CalOptima, a Managed Care Plan (MCP), from January 24, 2022 through February 4, 2022. The audit covered the period of February 1, 2020 through October 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 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]

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

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

Diana Voong, Contract Manager
Medi-Cal Managed Care Division
Department of Health Care Services

ATTACHMENT A
Corrective Action Plan Response Form

Plan: CalOptima **Review Period:** 2/1/2020 – 10/31/2021

Audit Type: Medical Audit and State Supported Services **Onsite Review:** 1/24/2022 – 2/4/2022

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 (*already completed*), 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
1. Utilization Management				
1.4.1 The Plan's delegation oversight of Post-Stabilization Authorization that was processed by its delegated entity, Prospect Medical Group, did not ensure that the PSA requests from outside of the Plan's network were approved or denied within the required time frame of 30 minutes, or deemed them automatically approved if the decision was not rendered within this required time frame.	In response to the finding that the Plan's delegation oversight of Post-Stabilization Authorization did not ensure that the PSA requests from outside of the Plan's network were approved or denied within the required time frame of 30 minutes or deemed them automatically approved if the decision was not rendered within this required time frame, the Plan respectfully notes the following remediation efforts: 1. The Plan's Audit & Oversight (A&O) department incorporated the PSA file review into the 2022 annual audits for each delegate (Attachment 1). 2. In addition to adding the PSA file review to the annual audits, the A&O department updated the delegation oversight dashboard (Attachment 2) to include the PSA turnaround times (TAT) metrics. The dashboard is collected from each delegate on a monthly basis to assist with tracking the delegates' PSA requirements. Upon receipt, the dashboard is monitored for compliance and assessed for potential CAP issuance. 3. The Plan's A&O department issued a corrective action plan (CAP) to Prospect on July 11, 2022, regarding the Post-Stabilization File review. As a result of this CAP, Prospect provided training	1.4.1_Attachment 1_2022 DOAA Engagement Webinar Presentation - Template_v.2022.2 1.4.1_Attachment 2_MC DELEGATION OVERSIGHT DASHBOARD 1.4.1_Attachment 3_Prospect CAP 1.4.1_Attachment 3_Prospect Training_22-08-23	1. May 1, 2022 2. May 1, 2022 3. July 11, 2022 August 23, 2022	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** Plan Policy GG1619 (revised date 12/3/20) states that the Plan shall oversee the functions, responsibilities, processes, and performance of a delegated entity and its services. The Plan's oversight activities included a review of compliance with regulatory requirements, contractual requirements, and Plan policies and procedures. Prospect's Policy MM2025 (revised 1/30/2020) states that within 30 minutes, a PSA request would be approved or denied with further coordination of the care. **TRAINING** 8/23/22 Meeting Agendas and Attendance sheets demonstrates the delegate has trained its inpatient team

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	to their Inpatient team to ensure all staff were aware of the PSA requirements.			on PSA requirements as corrective action for the CAP issued by the MCP. Medi-Cal Post-Stabilization Training for health networks to reinforce compliance with PSA timeframes. **MONITORING** The MCP incorporated the PSA file review into the 2022 annual audits webinar for each delegate. Oversight dashboards were updated to contain the PSA turnaround times for each delegate. The MCP receives a data extract from the delegated health networks on a monthly basis. The data is then utilized to calculate the TAT. Examples of CAPs sent to a delegate based on the results of their Post-Stabilization file review, demonstrating the MCP has a process in place to escalate non-compliance for further actions as stated in policy GG.1619.

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				The MCP submitted examples of nine CAP issued to delegates that were not meeting PSA time frames. The CAPs issued demonstrate the MCP's PSA file review is identifying issues and that the MCP has a process in place to require corrective action from the delegates. **The corrective action plan for finding 1.4.1 has been accepted.**
2. Case Management and Coordination of Care				
2.1.1 The Plan did not ensure the provision of oral or written anticipatory guidance by its network providers to the parents or guardians of child members ages six months and continuing until 72 months.	In response to the finding to ensure the provision of oral or written anticipatory guidance to the parent/guardians of child members ages 6-72 months by the Plan's network providers, the Plan respectfully notes the following remediation efforts: **1. 2022 Member Record Review Tool** (Attachment 1) Beginning July 1, 2022, in accordance with the CalOptima Health's policy GG.1717: Blood Lead Screening of Young Children, the Plan began use of the DHCS Medical Record Review (MRR) Tool, issued July 1, 2022, during the Facility Site Review (FSR) that contains pediatric prevention criteria to	2.1.1_Attachment 1_2022 Medical Record Review Tool and Comprehensive Health Assessment form	1. July 1, 2022: FSR team implemented the MRR tool. January 31, 2023: The Plan will make the Comprehensive Health Assessment forms available on the Plan's website.	The following documentation supports the MCP's efforts to correct this finding: **POLICY AND PROCEDURES** - "DHCS Medical Record Review Tool" which demonstrates that the MCP utilizes this tool for pediatric preventive review criteria to determine if blood lead anticipatory guidance was provided for child members aged six months to 72 months (Attachment 1_2022 Medical Record Review Tool and Comprehensive Health Assessment form).

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	determine if blood lead anticipatory guidance was provided. During the FSR process, if network providers are identified as needing support with proper medical record documentation of anticipatory guidance, the Plan educates the provider on the anticipatory guidance requirement and provides the Comprehensive Health Assessment forms as a tool. The Plan will make the Comprehensive Health Assessment forms available on the Plan's website. **2. Attestation** (Attachment 2) September 26, 2022: The Plan created the DHCS APL 20-016 Health Network/Delegate Attestation Form for Health Networks to attest that they will ensure that network providers will provide anticipatory guidance and adhere to additional blood lead management guidelines. The Plan finalized the process to share the DHCS APL 20-016 Health Network/Delegate Attestation Form with Health Networks, track form submissions, and monitor compliance with form submission. **3. Internal Policy GG.1717** Internal policy GG.1717 Blood Lead Screening of Young Children previously outlined requirements for Health Networks and Providers to provide oral or written anticipatory	2.1.1_Attachment 2_Attestation 2.1.1_Attachment 3_Anticipatory Guidance and Blood Lead Refusal Form	2. September 26, 2022: implemented the attestation process to ensure anticipatory guidance will be provided to child members. 3. January 31, 2023: The projected policy effective date. February 2023: The Plan will issue a policy update to delegated Health Networks. 4. June 2022: Plan developed the	"DHCS APL 20-016 Health Network/Delegation Attestation" which demonstrates that network providers have attested to ensure providing blood lead anticipatory guidance. (Attachment 2_Attestation). - Form, "Evidence of Blood Lead Testing Voluntary Refusal" to demonstrate the documentation of anticipatory guidance in the medical record and to obtain signed statement of voluntary refusal if the parent/guardian withheld consent to test (Attachment 3_Anticipatory Guidance and Blood Lead Refusal Form). - Updated P&P, "GG.1717: Blood Lead Screening of Young Children" (01/01/23) which include requirements for Health Networks and Providers to provide oral or written anticipatory guidance. The Health Network Attestation process requires network providers to attest to the provision of oral or written anticipatory guidance. (Attachment 11_GG.1717_Blood Lead Screening of Young Children_01-01-23).

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	guidance. The policy is currently being updated to include the Health Network Attestation process that requires them to attest to the provision of oral or written anticipatory guidance. **4. Anticipatory Guidance and Blood Lead Refusal Form** (Attachment 3) June 2022: The Plan developed the Anticipatory Guidance and Blood Lead Refusal Form to support the documentation of anticipatory guidance in the medical record and to obtain signed statement of voluntary refusal if the parent/guardian withheld consent to test. The Anticipatory Guidance and Blood Lead Refusal form was translated to all threshold languages and made it available on the Plan's website on October 12, 2022, to support Providers with the documentation in the child's medical record of the provision of oral or written anticipatory guidance as well as the refusal of blood lead tests. **5. Provider Education Efforts** The Plan has implemented various efforts to educate Health Networks and Providers about anticipatory guidance requirements as follows: a. April 11, 2022: The Plan shared the California Department of Public Health	2.1.1_Attachment 4_Testing Requirements and Anticipatory Guidance Resources to Health Networks 2.1.1_Attachment 5_Attestation Requirement Updates to Health Networks__AltaMed Example	Anticipatory Guidance and Blood Lead Refusal Form. October 12, 2022: The Plan translated to all threshold languages and made available on the Plan's website the Anticipatory Guidance and Blood Lead Refusal Form. 5a. April 11, 2022: The Plan shared CDHP resources with Health Networks. January 31, 2023: Additional planned efforts include to make the CDPH anticipatory	**TRAINING** - "CalOptima's Weekly Communication" (04/11/22) to demonstrate that the MCP sent an email notification to network providers regarding blood lead anticipatory guidance requirements (Attachment 4_Testing Requirements and Anticipatory Guidance Resources to Health Networks). - "CalOptima Health Community Network Virtual Meeting" (10/11/22) to demonstrate that the MCP provided updates to contracted providers on requirements for anticipatory guidance, and use of the MCP's Evidence of Blood Lead Refusal form to document anticipatory guidance (Attachment 6_CCN Virtual Meeting_Blood Lead Screening Updates, Page 20). - "2022 Year End Well Child and Lead Reminder Call Outreach Plan" to demonstrate that the MCP conducted outreach calls and text campaign to members who were identified as non-compliant with the Lead Screening in Children (LSC) HEDIS measure

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	(CDPH) resources to support blood lead anticipatory guidance requirements and blood lead management to the Health Networks (Attachment 4). January 31, 2023: Additional planned efforts include to make the CDPH anticipatory guidance handout available on the Plan's website. b. August 1, 2022: The Plan began providing updates during regular quality meetings to Health Networks regarding the Plan's attestation requirements to ensure the provision of anticipatory guidance through the DHCS APL 20-016 Health Network/Delegate Attestation Form as well as the forthcoming updates to the CalOptima Health policy GG.1717 that outline the attestation requirements (Attachment 5). c. October 11, 2022: The Plan shared updates at a Virtual Meeting for directly contracted providers on requirements including anticipatory guidance, use of the Plan's Evidence of Blood Lead Refusal form to document anticipatory guidance, sources of lead, requirements on using data in the blood lead quarterly reports that identifies	2.1.1_Attachment 6_CCN Virtual Meeting_Blood Lead Screening Updates 2.1.1_Attachment 7_Blood Lead CME Workshop Flyer_Oct 22 2.1.1_Attachment 8_Blood Lead Updates at Health Network Forum_Nov 2022	guidance handout available on the Plan's website. 5b. August 1, 2022: Updates provided during regular quality meetings. 5c. October 11, 2022, Updates shared at a Virtual Meeting for directly contracted providers. 5d. October 12 & 26, 2022: The Plan held a Continuing Medical Education event that included anticipatory guidance requirements as well as blood lead testing and	(Attachment 9_Member Education Efforts, Page 20). - Newsletter, "Provider Update" (02/01/23) which demonstrates that the MCP has informed contracted providers of anticipatory guidance, the new blood lead reference value, blood lead testing requirements and resources on where to stay informed on the latest blood lead recommendations. (Attachment 16_CalOptima Health February 2023 Provider Update). - "PBS Ad Campaign Schedule" (FY 2002 –2023) which demonstrates the MCP's television ad campaign regarding this topic. (Attachment 19_PBS Campaign Schedule). - "Blood Lead Screening Robocall Campaign Summary" which demonstrates that a blood lead robocall campaign was conducted from March 15, 2023, through March 28, 2023. (Attachment 25_Caloptima Health Lead Screening Robocall Campaign Summary).

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	children that have not been screened for lead as recommended (Attachment 6). d. October 12 & 26, 2022: The Plan conducted a Continuing Medical Education (CME) event focused on risk factors, management and treatment of lead exposure, and lead screening regulations including anticipatory guidance (Attachment 7). e. November 17, 2022: The Plan shared updates on blood lead as part of the Health Network Quality Forum. Updates included the introduction of the Anticipatory Guidance and Blood Lead Refusal form to support documentation of refusal of blood lead tests and anticipatory guidance provided. In addition, Health Networks were reminded of the new requirement to attest to operational and regulatory requirements which include ensuring the provision of anticipatory guidance and testing for blood lead (Attachment 8). **f.** July 31, 2023: Additional planned efforts to inform contracted providers of providers of anticipatory guidance, the new blood lead reference value, blood lead testing requirements and resources on where to stay informed on the latest blood lead	2.1.1_Attachment 9_Member Education Efforts	management guidelines. 5e. November 17, 2022: Updates provided on blood lead screening provided as part of Health Network forum. 5f. July 31, 2023: Additional planned efforts to inform contracted providers of providers of anticipatory guidance, the new blood lead reference value, blood lead testing requirements and resources on where to stay informed on the latest blood lead recommendations via the Provider Press Newsletter.	**MONITORING AND OVERSIGHT** - "Primary Care Provider MRR Standards" which demonstrates that the 2022 Pediatric Preventive Criteria is included in the Primary Care Provider MRR standards. This document accompanies the MRR tool and provides the specific instructions for conducting the review for blood lead anticipatory guidance to ensure that it is provided for child members aged six months to 72 months. (Attachment 24_Primary Care Provider MRR Standards). **The corrective action plan for Finding 2.1.1 is accepted.**

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	recommendations via the Provider Press Newsletter. **6. Member Education Efforts** (Attachment 9) As a safety net to Provider based anticipatory guidance, the Plan has implemented the following education efforts to provide members with anticipatory guidance as follows: **a**. Member Medical Newsletters April 12, 2022: How to Protect Your Family from Lead Poisoning article in the Medi-Cal newsletter mailed to 503,680 members. April 27 - 29, 2022: "Sticky Hands!" article in the Medi-Cal newsletter mailed to 535,741 members. The "Sticky Hands!" article outlines sources of lead and encourages members to speak to doctor about blood lead testing. **b.** July 9, 2022: Member robocalls issued to members who were identified as non-compliant with the Lead Screening in Children (LSC) HEDIS measure and had a landline or cell phone with Telephone Consumer Protection Act (TCPA) consent for outreach. The Plan has an additional member robocall campaign planned for March 2023.		6a. April 12, 2022: The Plan mailed newsletter mailed to members. April 27 -29, 2022: The Plan sent the "Sticky Hands!" Article to members. 6b. July 9, 2022: The Plan implemented a robocall campaign. 6c. October 12, 2022: The Plan conducted a Well Child and Lead Call Campaign. 6d. December 6, 2022: The Plan conducted a text campaign targeting members that are not	

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	c. October 12, 2022: The Plan conducted a Well Child and Lead Call Campaign targeting 1,953 members who have not been screened for lead in accordance with the LSC HEDIS Measure and are also due for a well-child visit. **d**. December 6, 2022: The Plan conducted a text campaign targeting members that are not compliant with the lead screening in children HEDIS measure. The Plan will actively continue to provide members with anticipatory guidance. **e**. January 1, 2023: The Plan will conduct a PBS television ad campaign that advises parents/guardians that a lead test is the only way to identify if a child has been exposed to lead.		compliant with the lead screening in children HEDIS measure. The Plan will actively continue to provide members with anticipatory guidance. 6e. January 1, 2023: The Plan will conduct a PBS television ad campaign that advises parents/guardians that a lead test is the only way to identify if a child has been exposed to lead. March 2023: The Plan has an additional member robocall campaign planned.	
2.1.2 The Plan did not ensure the provision of blood lead screening tests to child members at 12 months and 24	In response to the identified finding, to ensure the provision of blood lead screening tests to child members at 12 months and 24 months of age and up to 72 months, the Plan respectfully notes the following remediation efforts:			The following documentation supports the MCP's efforts to correct this finding: **POLICY AND PROCEDURES** - "DHCS Medical Record Review Tool" which demonstrates that the MCP

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months of age and up to 72 months when there were no documented blood lead screenings. The Plan sent lists of child members who missed the screening tests to their health network delegates. However, the Plan did not ensure the Primary Care Providers (PCP) received these lists or provided the services to child members.	1. **2022 Member Record Review Tool** (Attachment 1) Beginning July 1, 2022, in accordance with the CalOptima Health policy GG.1717: Blood Lead Screening of Young Children, the Plan began use of the DHCS Medical Record Review (MRR) Tool issued July 1, 2022, during the Facility Site Review (FSR) process to identify if blood lead testing was completed by eligible members. If the FSR process determines that a blood lead screening was not provided to an eligible member, the FSR team educates the provider on the blood lead testing requirements and recommends that a member is screened for lead. During the FSR process, if it is determined that a network provider needs support with proper medical record documentation of blood lead testing and management, the Plan will make the Comprehensive Health Assessment forms available. Additional efforts by the Plan include to make the Comprehensive Health Assessment forms available on the Plan's website. 2. **Blood Lead Gap Report** (Attachment 2) On April 29, 2022, the Plan transitioned delegated and directly contracted providers to a new provider portal called In-House Provider	2.1.2_Attachment 1_2022 Medical Record Review Tool 2.1.2_Attachment 2_ Sample Blood Lead Screening Gap Report 2.1.2_Attachment 3_Sample Provider Dashboard Summary	1. July 1, 2022: FSR team implemented the MRR tool. January 31, 2023: The Plan will make the Comprehensive Health Assessment forms available on the Plan's website. 2. January 31, 2023: the Plan will make enhancements to the report to include a dashboard summary of provider compliance rates to support Health Networks with analysis.	utilizes this tool for pediatric preventive review criteria to determine if blood lead anticipatory guidance was provided for child members aged six months to 72 months (Attachment 1_2022 Medical Record Review Tool and Comprehensive Health Assessment form). - “DHCS APL 20-016 Health Network/Delegation Attestation” which demonstrates that network providers will attest to ensure providing blood lead anticipatory guidance to child members ages six months and continuing until 72 months (Attachment 2_Attestation). - Updated P&P, “GG.1717: Blood Lead Screening of Young Children” which includes the Health Network Attestation process that requires providers to attest to the provision of oral or written anticipatory guidance (Attachment 11_GG.1717_Blood Lead Screening of Young Children_01-01-23). **TRAINING**

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	Portal ("Provider Portal"), an electronic platform to share quarterly blood lead gap reports. The Plan is currently working to enhance the blood lead gap report to provide Health Networks with a dashboard summary that can facilitate oversight by identifying the provider and their respective compliance rate with lead testing of child members (Attachment 3). In addition, the Plan is currently working to leverage the provider portal capabilities to drive delegated and directly contracted providers to download the reports in a timely manner. **3. Attestation** (Attachment 4) September 26, 2022: The Plan created the DHCS APL 20-016 Health Network/Delegate Attestation Form for Health Networks to attest on a quarterly basis to the receipt and review of the blood lead reports, distribution of the reports to subcontracted providers and adherence to the California Lead Poisoning Prevention Branch (CLPPB) standards of care for timely blood lead screenings and follow-up care. The Plan finalized the process to share the DHCS APL 20-016 Health Network/Delegate Attestation Form with Health Networks, track form submissions quarterly, and monitor compliance quarterly with form submission. **4. Internal Policy GG.1717**	2.1.2_Attachment 4_Attestation 2.1.2_Attachment 5_MY 2022 P4V Measures	January 31, 2023: The Plan will develop attestation alerts in the Provider Portal for contracted providers to be automatically alerted that their attestation submission is due. February 28, 2023: The Plan will develop an automated process for contracted providers to receive email alerts to notify providers that their attestation is due. 3. September 26, 2022: implemented the attestation process to support timely blood lead testing in accordance with the California Lead Poisoning Prevention Branch testing guidelines and attest to the receipt, retrieval of blood lead report and	- "CalOptima Health Community Network Virtual Meeting" (10/11/22) to demonstrate that the MCP provided updates to contracted providers on requirements for anticipatory guidance, and use of the MCP's Evidence of Blood Lead Refusal form to document anticipatory guidance. (Attachment 8_CCN Virtual Meeting_Blood Lead Screening Updates, Page 20). - "2022 Year End Well Child and Lead Reminder Call Outreach Plan" to demonstrate that the MCP conducted outreach calls and text campaign to members who were identified as non-compliant with the Lead Screening in Children (LSC) HEDIS measure (Attachment 11_Member Education Efforts, Page 20). - Newsletter, "Provider Update" (02/01/23) which demonstrates that the MCP has informed contracted providers of anticipatory guidance, the new blood lead reference value, blood lead testing requirements and resources on where to stay informed on the latest blood lead recommendations. (Attachment

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	Internal policy GG.1717 Blood Lead Screening of Young Children previously outlined requirements for Health Networks and Providers to provide oral or written anticipatory guidance. The policy is currently being updated to include the Health Network Attestation process that requires them to attest to the provision of oral or written anticipatory guidance. **5. Pay for Performance** (Attachment 5) January 1, 2022: The Pay for Value (P4V) program is an incentive program for Health Networks who perform well on selected measures. The main objective of the P4V program is to promote quality, deliver quality preventive health services and support member satisfaction. To drive blood lead screening rates In Measure Year 2022, the Lead Screening in Children (LSC) HEDIS measure was added to the Plan's P4V program for delegated and directly contracted providers. Payments for health networks with occur during 2023 for performance. **6. Provider Education Efforts** The Plan has implemented various efforts to educate Health Networks and Providers about blood lead testing requirements.	2.1.2_Attachment 6_Testing Requirements and Anticipatory Guidance Resources to Health Networks 2.1.2_Attachment 7_Attestation Requirement Updates to Health Networks__AltaMed Example	distribution to delegated health networks. December 31, 2022: The Plan will implement the attestation process for directly contracted providers via the Plan's Provider Portal for attestation of the same requirements. 4. January 31, 2023: The projected policy effective date. February 2023: The Plan will issue a policy update to delegated Health Networks 5. January 1, 2022: The Plan included Lead Screening in Children (LSC) HEDIS measure in the Plan's Pay for Value program for 2022	16_CalOptima Health February 2023 Provider Update). - “PBS Ad Campaign Schedule” (FY 2002 –2023) which demonstrates the MCP’s television ad campaign on PBS that advises parents/guardians that a lead test is the only way to identify if a child has been exposed to lead. (Attachment 19_PBS Campaign Schedule). - “Blood Lead Screening Robocall Campaign Summary” which demonstrates that a blood lead robocall campaign was conducted from March 15, 2023, through March 28, 2023. A total of 3,801 members received a message or successfully listened to the blood lead robocall message. (Attachment 25_Caloptima Health Lead Screening Robocall Campaign Summary). - Updated, “Provider Portal” which demonstrates that the MCP has further enhanced the attestation alerts in the Provider Portal to alert contracted providers when their attestation submission is overdue. The attestation

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	a. April 11, 2022: The Plan shared the California Department of Public Health (CDPH) resources to support blood lead anticipatory guidance requirements and blood lead testing and management guidelines to the Health Networks (Attachment 6). b. August 2022: The Plan began providing updates during regular quality meetings to Health Networks regarding the Plan's attestation requirements through the use of the DHCS APL 20-016 Health Network/Delegate Attestation Form to ensure the provision of blood lead testing and management in accordance with the California Lead Poisoning Prevention Branch minimum standards of care. Health Networks were also informed of the forthcoming updates to CalOptima Health policy GG.1717 that outline the attestation requirement (Attachment 7). c. October 11, 2022: The Plan shared updates at a Virtual Meeting for directly contracted providers on requirements including access and use of the reports, requirements to review data and test members who have not been screened for lead, instructions on the use of the Evidence of Blood Lead Refusal	2.1.2_Attachment 8_CCN Virtual Meeting_Blood Lead Screening Updates 2.1.2_Attachment 9_Blood Lead CME Workshop Flyer_Oct 22 2.1.2_Attachment 10_Blood Lead Updates at Health Network Forum_Nov 2022	to support timely blood lead testing. 6a. April 11, 2022: The Plan shared CDHP resources with Health Networks. January 31, 2023: Additional planned efforts include to make the CDPH anticipatory guidance handout available on the Plan's website. 6b. August 1, 2022: Updates provided during regular quality meetings. 6c. October 11, 2022, Updates shared at a Virtual Meeting for directly contracted providers.	is an effort to drive blood lead report utilization to identify untested members and support provider outreach efforts for lead testing. (Attachment 23_CalOptima Health Provider Portal Release Notes, Sample Provider Portal with Enhanced Alert Features). - Sample, “Email Notification to Providers” which demonstrates that the MCP has developed an automated process for contracted providers to receive email alerts to notify that their attestation is due. (Attachment 30_Sample Email Notification to Providers). **MONITORING AND OVERSIGHT** - Sample, “Blood Lead Screening Gap Report” and “Provider Dashboard Summary” to demonstrate that the MCP has created a dashboard summary of the quarterly Blood Lead reports to highlight members who have not been tested for blood lead (Attachment 2_Sample Blood Lead Screening Gap Report, Attachment

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	form to document anticipatory guidance, and blood lead refusals that count as meeting the testing requirements (Attachment 8). d. October 12 & 26, 2022: The Plan conducted a Continuing Medical Education (CME) event focused on risk factors, lead testing requirements and blood lead management and lead screening regulations including the provision of anticipatory guidance (Attachment 9). e. November 17, 2022: The Plan shared updates on blood lead as part of the Health Network Quality Forum (Attachment 10). Updates include the introduction of the Anticipatory Guidance and Blood Lead Refusal Form to support documentation of refusal of blood lead tests and anticipatory guidance provided. In addition, Health Networks were reminded of the new requirement to attest to operational and regulatory requirements which include testing for blood lead as required by California Lead Poisoning Prevention Branch. Additional planned efforts include to make the CDPH standards of care links available on the Plan's website. **7. Member Education Efforts** (Attachment 11)	2.1.2_Attachment 11_Member Education Efforts	6d. October 26, 2022: The Plan conducted a Continuing Medical Education event that will focus on educating providers on blood lead testing and other blood lead management guidelines. 6e. November 17, 2022: Updates provided on blood lead screening provided as part of Health Network forum. 7a. April 12, 2022: The Plan mailed newsletter mailed to members.	3_Sample Provider Dashboard Summary). - "Blood Lead Screening Report" to demonstrate that the MCP monitors on a monthly basis the member progress with testing at the 12-month and 24-month timeframe by provider. The provider summary includes testing rates for the month in which the report data is based on and the month prior to showcase month to month progress with testing. (Attachment 37 Blood Lead Performance Report). - "Blood Lead Test Outreach Report" to demonstrate that the MCP conducts a monthly report that proactively identifies members 1-3 months prior to the 12-month and 24-month lead test due date for the purpose of outreach to be made by Health Network providers. (Attachment 38 Blood Lead Test Outreach Report). **The corrective action plan for finding 2.1.2 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	As a safety net to Provider based education, the Plan has implemented the following education efforts to advise members of blood lead testing requirements in support of Provider based education. a. Member Medical Newsletters April 12, 2022: How to Protect Your Family from Lead Poisoning article in the Medi-Cal newsletter mailed to 503,680 members. April 27 - 29, 2022: "Sticky Hands!" article in the Medi-Cal newsletter mailed to 535,741 members. The "Sticky Hands!" article outlines sources of lead and encourages members to speak to doctor about blood lead testing. b. July 9, 2022: Member robocalls issued to members who were identified as non-compliant with the Lead Screening in Children (LSC) HEDIS measure and had a landline or cell phone with TCPA consent for outreach. The Plan has an additional member robocall campaign planned for March 2023. c. October 12, 2022: The Plan conducted a Well Child and Lead Call Campaign targeting 1,953 members who have not been screened for lead in accordance with		April 27 -29, 2022: The Plan sent the "Sticky Hands!" Article to members. 7b. July 9, 2022: The Plan implemented a robocall campaign. 7c. October 12, 2022: The Plan conducted a Well Child and Lead Call Campaign. 7d. December 6, 2022: The Plan conducted a text campaign targeting members that are not compliant with the lead screening in children HEDIS measure. The Plan will actively continue to provide	

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	the LSC HEDIS Measure and are also due for a well-child visit. d. December 6, 2022: The Plan conducted a text campaign targeting members that are not compliant with the lead screening in children HEDIS measure. The Plan will actively continue to provide members with anticipatory guidance. e. January 2023: The Plan will conduct a PBS television ad campaign that advises parents/guardians that a lead test is the only way to identify if a child has been exposed to lead.		members with anticipatory guidance. 7e. January 1, 2023: The Plan will conduct a PBS television ad campaign that advises parents/guardians that a lead test is the only way to identify if a child has been exposed to lead. March 2023: The Plan has an additional member robocall campaign planned.	
3. Access and Availability of Care				
3.8.1 The Plan did not ensure that Physician Certification Statements included the start and end dates for NEMT services.	In response to the finding, to ensure the Plan's Physician Certification Statement (PCS) forms have start and end dates for authorized non-emergency medical transportation (NEMT) services, the Plan respectfully notes the following remediation efforts: 1. April 19, 2022: The Plan updated the NEMT desktop procedures (DTP) (Attachment 1) to ensure staff processing of NEMT services includes the updated PCS form with start and	3.8.1_Attachment 1_DTP 43 Processing Service Requests for NEMT (Updated) 3.8.1_Attachment 2_DTP 43 & PCS Form Training_May	1. April 19, 2022: The Plan modified the DTP 43: Processing Service Requests for NEMT. May 3, 2022: The Plan trained its staff on the DTP 43.	The following documentation supports this finding: **POLICIES AND PROCEDURES & PROCEDURES** The Plan updated P&Ps to address the gap that contributed to the deficiency: • Plan procedure "DTP 43_Processing Srvc

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	end dates. The Utilization Management (UM) department conducted training on May 3, 2022 (Attachment 2) specifically on NEMT Authorization Request forms (ARF) to ensure compliance with the updates made to the DTP. 2. May 31, 2022: The UM department requested the Regulatory Affairs and Compliance (RAC) department to send the updated PCS form to DHCS for review (Attachment 3). 3. June 8, 2022: The UM department conducted additional training on DTP 43 noting that the proposed ARF form was still being reviewed by DHCS (Attachment 4). 4. June 10, 2022: The Plan received approval from DHCS for the new PCS form (Attachment 5) to include start and end dates. 5. June 23, 2022: The Communications department reviewed the updated PCS form and uploaded to the public website (Attachment 6). 6. June 24, 2022: The UM department notified Provider Relations department to communicate the updated PCS form to providers (Attachment 6).	3.8.1_Attachment 3_NEMT PCS Form Review Request through RAC 3.8.1_Attachment 4_DTP 43 & PCS Form Training_June 3.8.1_Attachment 5_PCS Form 3.8.1_Attachment 6_NEMT PCS Communications and PR 3.8.1_Attachment 7_NEMT PCS Notification to PA Team 3.8.1_Attachment 8_CCN	2. May 31, 2022: The Plan sent updated PCS form to DHCS for approval. 3. June 8, 2022: The Plan trained its staff on the DTP 43. 4. June 10, 2022: The Plan received approval from DHCS. 5. June 23, 2022: The Plan uploaded the PCS form to public website. 6. June 24, 2022: The Plan notified Providers of the updated PCS form. 7. June 24, 2022: The Plan notified its staff on the approval and posting of the updated NEMT PCS form on the public website.	Requests_NEMT" demonstrates the Plan's requirement to ensure the PCS form includes start & end dates; authorizations may be for a maximum of 12 months. [Process Steps, 2., page 2] • Plan policy "GG.1505: Transportation: Emergency, NEMT_NMT" demonstrates the Plan's requirement to ensure the PCS form is completed & that it includes transportation dates for NEMT services. [III. Procedure, B.1.b., page 10] • Plan Request Form "PCS Form" was approved by DHCS MCOD 06/10/2022. The PCS form includes all necessary components & clearly indicates "start date" & "end date". **IMPLEMENTATION/OVERSIGHT & MONITORING** The Plan identified, developed and deployed an internal auditing process to continuously self-monitor to detect and prevent future non-compliance:

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	7. The UM team was notified that the NEMT PCS form has been approved and live on the public website. (Attachment 7) 8. July 19, 2022: The Plan held a Provider Lunch and Learn event that educated on the updated NEMT PCS Form (slide 44-46) (Attachment 8). 9. November 2, 2022: The Plan updated the NEMT audit tools (Attachment 9) to clearly specify start and end dates. 10. November 3, 2022: The Plan developed a Monthly Audit Review NEMT DTP (Attachment 10) and provided training (Attachment 11) to the UM In-Line monitoring team.	Virtual Meeting July 2022_Final_V2 3.8.1_Attachment 9_Updated CCN NEMT Audit Tools 3.8.1_Attachment 10_DTP 41 - Monthly Audit Review NEMT 3.8.1_Attachment 11_DTP 41 Training	8. July 19, 2022: The Plan held a Provider Lunch and Learn event in July that shared the updated NEMT PCS Form. 9. November 2, 2022: The Plan updated the Routine and Urgent Audit Tools to clearly specify start and end dates. 10. November 3, 2022: The Plan developed a Monthly Audit Review NEMT DTP (41) and trained its staff.	• Plan policy "GG.1505: Transportation: Emergency, NEMT_NMT" o At least quarterly, monitoring & oversight includes a random selection & review of all NEMT requests. o The Plan does not delegate these monitoring & oversight activities to the NEMT transportation providers. [II. Policy, Q.2.c., Page 9] • Plan procedure "DTP 41_Monthly Audit Review" o On a monthly basis, the Plan reviews a random selection of a maximum of 30 files for the NEMT audit to review for timeliness of the determination, clinical decision making, accuracy, documentation of dates of service (start & end), process flow, & notification delivery. [Page 2 & 3, 5. Review of Files]

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				○ Issues that are identified will be forwarded to the UM manager to determine the root cause & corrective action plan to prevent reoccurrence. • Plan procedure "DTP 31_Processing_Routine_Urgent_Referral_Requests_Providers (ARFs)" ○ If a PCS form is found to be incomplete & three (3) attempts are made to obtain missing information & unsuccessful, the request is sent to Medical Director (MD) for review. MD will make a final determination - if denial is determined, a NOA letter is sent & system is updated due to lack of/missing information & unsuccessful attempts. [Nurse Processing, 15., page 8]

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

				• Plan procedure "DTP 43_Processing Srvc Requests_NEMT"
				  ○ The Plan updated the NEMT DTP to ensure staff processing NEMT services utilize the updated PCS forms with start & end dates. [Process Steps, 2., page 2]
				
				• PROVIDER TRAINING/NOTIFICATIONS
				  ○ Various provider notifications & trainings took place ensuring the Plan has made all providers aware of the new requirement & PCS form availability on the Plan's website, etc. [See NEMT PCS, DTP 43 Trainings, & DTP 41 Training]
				
				The corrective action plan for finding 3.8.1 is accepted.

4. Member Rights				

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
4.1.1 The Plan did not send resolution letters for quality-of-service grievances within the required 30 calendar days.	In response to the timely resolution and notification for quality of service finding, the Plan respectfully notes the following remediation efforts: **1. Staffing Enhancements** May 2022: Completed hiring of additional Specialists (Nurse Specialist and Grievance Specialist) to improve staff to case ratio. This adjusted the caseload for both the Resolution Specialist and the Nurse Specialist which has allowed for full resolution and timely case closure **2. Refresher Trainings** May 2022: Staff meeting included an overview of suggestions/requirements for timely case closure, cultural & linguistic team needs to ensure case turnaround times meet case timeliness and the introduction of individual scorecards for additional monitoring. (Attachment 1). August 2022: Staff meeting included a team performance driven refresher training and an overview of the changes made to the GARS SharePoint site. The GARS SharePoint site includes but is not limited to regulations and policies that govern the work, desktops, letter templates, and refresher trainings. (Attachment	4.1.1_Attachment 1_ May 2022 Staff Meeting 4.1.1_Attachment 2_August 2022 Staff Meeting	2. May 11, 2022: Staff training 2. August 8, 2022: Staff training	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** - Desk Top Procedure, "Scorecard Process" (09/22) which demonstrates the required activities, documents, actions, and turn-around times in a sample case selection meet regulatory requirements, including CalOptima policies and procedures. - Desk Top Procedures, "Internal Auditing Process for A&O Reporting" (07/22) which documents the process for which the Grievance and Appeals Resolution Services (GARS) departmental auditors will conduct audits required/requested by the CalOptima Health Audit and Oversight (A&O) Department. The monthly audits review for compliance of all GARS related policies and procedures, regulatory requirements, and system activities. **TRAINING**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	2). .			- Staff Meeting, “Staff Training” (05/11/22) which demonstrates staff received a refresher training in regard to timely case closure of QOS grievances. - Staff Meeting, “Staff Training” (08/08/22) an overview of the changes made to the Grievance and Appeals and Resolution Services (GARS) SharePoint site. **MONITORING/OVERSIGHT** - Audit Tool, “Internal Audit Tool” (2022) demonstrates the MCP is monitoring that resolution turn-around times are met within the 30-calendar day timeframe. - Audit Report, “Core Report with Daily Turn-Around Time (TAT) of Grievances” (03/23) which demonstrates the daily reporting used to track the cases due date, timeliness, and aging of cases. The MCP is auditing these daily reports on a monthly basis. All 189 cases reported in this daily report were 100% compliant.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				- Audit Report, “GARS KPI and Department File Review TAT of Grievances” (Q1 - Q4 2022) which demonstrates he MCP is monitoring monthly for timely resolution of grievances within the 30-calendar day timeframe. The cases reported had a compliancy rate of 98.6% - 100%. - Form, “Pre-Corrective Action Plan Form” (2022) as evidence when non-compliance issues are identified at the staff level, they are addressed by the issuance of a Pre-Cap, which will also include any individual coaching, updates needed and/or departmental training opportunities. **STAFFING** - Hiring of additional staff, (05/22) the MCP hired a Nurse Specialist and Grievance Specialist. These additional hires have adjusted the case load of grievances which allows for timely case closure and full resolution. **The corrective action plan for finding 4.1.1 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
4.1.2 The Plan did not ensure its delegate met the standards set forth by the Plan and DHCS. The delegate did not send the quality-of-service grievance resolution letters within the required 30 calendar days.	In response to the finding regarding the Plan not ensuring its delegate sends the quality-of-service grievance resolution letters within the required 30 calendar days, the Plan respectfully notes the following remediation efforts: 1. The Plan's Audit and Oversight (A&O) department updated the delegation oversight dashboard (Attachment 1) to include resolution turnaround time for Kaiser grievances. The dashboard is collected from Kaiser on a quarterly basis to assist with tracking Kaiser's resolution timeliness. If the metric is below the established threshold the auditor will review the metric with the Grievance department to determine if CAP issuance is necessary. 2. The A&O department will continue to review grievances, including the timeframe for issuing quality of service grievance resolution letters, in our annual audits and issue corrective action plans (CAPs) when deficiencies are identified (Attachments 2 and 3).	4.1.2_Attachment 1_MC DELEGATION OVERSIGHT DASHBOARD.1 4.1.2_Attachment 2_CalOptima_2022 DOAA Grievance (GA) Audit Tool 4.1.2_Attachment 3_CalOptima_2022 File Review_Medi-Cal_Grievances	1. November 1, 2022 2. November 1, 2022 3. November 1, 2022	The following documentation supports the MCP's efforts to correct this finding: **POLCIES & PROCEDURES** The MCP submitted GG.1619, "Delegation Oversight Policy" (12/20/21) which includes language that states, "Delegated Entity Dashboard Reporting: On a monthly basis, data submitted by the Delegated Entities shall be used to monitor areas of timeliness and accuracy. The AOC shall monitor the dashboards and may make recommendations for Corrective Action should metrics fall below the threshold. If there is a consistent pattern of noncompliance by the Delegated Entity, the Audit & Oversight Department will conduct a focused review. If the results of the focused review are unfavorable, the Auditor will

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	3. The GARS department will escalate to A&O as issues are identified and continue to track and trend reporting of Kaiser grievances (Attachment 4). 4. A&O reached out to Kaiser, and they ensured resolution letters will be sent to members within 30 calendar days. Kaiser indicated that the case processing staff were coach/counseled on November 16, 2022 (Attachment 5). Kaiser has also indicated that the following mitigation controls have been implemented: a. Daily: The Kaiser Grievance management team monitors and views daily reports/dashboard in Tableau (Attachment 6 and 7) in order to engage the case processing, staff to ensure compliance with due dates. The reports indicate upcoming due dates of letters and case/resolution. b. Quarterly: The management, leadership and Kaiser's national compliance team reviews a quarterly report that monitors for resolution timeframes and case quality (Attachment 8). If the report indicates non-compliance, it also demonstrates root cause analysis, and any improvement efforts made to meet compliance.	4.1.2_Attachment 4_CalOptima Health Plan Quarterly Report - Q3 2022 (Kaiser) 4.1.2_Attachment 5_ 2022 DHCS CalOPTIMA Attestation 4.1.2_Attachment 6_CA_HI Open Resolution_ Dashboard_redacted 4.1.2_Attachment 7_CAL_HI - Open Inventory Detail_redacted 4.1.2_Attachment 8_Q2 2022 Medicaid Health Plan Compliance Metrics Dashboard Appeals and Grievances_redactedV3	4. November 16, 2022: a & b	escalate to the AOC for further actions." **MONITORING/OVERSIGHT** - Reports, "Open Resolution Dashboard (11/22) and Open Inventory Details" (11/22) which demonstrates that the delegate's Grievance Management Team monitors and reviews daily reports/dashboard to assess compliance with due dates. Reports indicate upcoming due dates of letters and case resolution. - Dashboard Report, "Delegation Oversight Dashboard" (Review period 03/01/22 – 08/31/22) this dashboard information is collected on a quarterly basis from the delegate to monitor for resolution timeliness. The Corrective Action Plan (CAP) will remain open until three consecutive months of compliance reporting from the delegate for resolution timeliness. - Dashboard Report, "Q2 2022 Medicaid Health Plan Compliance Metrics Dashboard FINAL" (10/18/22) which demonstrates MCP is monitoring

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				for resolution timeframes. If non-compliance is shown, the MCP will give a root cause analysis and any efforts to improve in order to be compliant. - Audit Report, “CalOptima Health Plan Quarterly Report” (Q4 2022) demonstrates that the MCP has a monitoring process to track and trend standard grievance resolution letter dates to identify reoccurring issues. Out of the 337 cases reviewed, 89% were compliant with the standard resolution letters being sent to members within 30 calendar days. - Audit Tools, “2022 Readiness/Annual Assessment Grievance” and “2022 File Review Medi-Cal Grievances,” demonstrates the timely issuance of resolution letters are being monitored through the resolution timeframe. The Plan’s Auditors consider the resolution timeframes met when the letter is mailed out and not when a decision is made. Therefore, the 30 calendar days timeframe includes the letter being mailed.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				- Daily Report, “Open Inventory Detail Report” (as of 11/16/22) demonstrates the MCP is monitoring when grievances are received and when resolution is due within 30 calendar days as required. **DELEGATE REVIEW** - Email shared with the Delegate’s Senior Case Managers regarding cases where the resolution letters were issued past the 30 days of receipt of the grievance. Per the MCP, the delegate demonstrated the resolution letters will be sent to members within 30 calendar days and the delegate has trained case processing staff of this requirement on November 16, 2022. **The corrective action plan for finding 4.1.2 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
4.1.3 The Plan did not ensure its delegate met the standards set forth by the Plan and DHCS. The delegate did not send the quality-of-service grievance acknowledgment letters to members within five calendar days.	In response to the finding regarding the Plan not ensuring its delegate send the quality-of-service grievance acknowledgment letters to members within five calendar days, the Plan respectfully notes the following remediation efforts: 1. The Plan's Audit and Oversight (A&O) department updated the delegation oversight dashboard (Attachment 1) to include acknowledgement turnaround time for Kaiser grievances. The dashboard is collected from Kaiser on a quarterly basis to assist with tracking Kaiser's acknowledgement timeliness. If the metric is below the established threshold the auditor will review the metric with the Grievance department to determine if CAP issuance is necessary. 2. The A&O department will continue to review grievances, including the timeframe for issuing acknowledgement letters, in our annual audits and issue corrective action plans (CAPs) when deficiencies are identified (Attachments 2 and 3). 3. The GARS department will escalate to A&O as issues are identified and continue to track and trend reporting of Kaiser grievances (Attachment 4).	4.1.3_Attachment 1_MC DELEGATION OVERSIGHT DASHBOARD.1 4.1.3_Attachment 2_CalOptima_2022 DOAA Grievance (GA) Audit Tool 4.1.3_Attachment 3_CalOptima_2022 File Review_Medi-Cal_Grievances 4.1.3_Attachment 4_CalOptima Health Plan Quarterly Report - Q3 2022 (Kaiser)	1. November 1, 2022 2. November 1, 2022 3. November 1, 2022 4. November 16, 2022: a & b	The following documentation supports the MCP's efforts to correct this finding: **POLCIES & PROCEDURES** The MCP submitted GG.1619, "Delegation Oversight Policy" (12/20/21) which includes language that states, "Delegated Entity Dashboard Reporting: On a monthly basis, data submitted by the Delegated Entities shall be used to monitor areas of timeliness and accuracy. The AOC shall monitor the dashboards and may make recommendations for Corrective Action should metrics fall below the threshold. If there is a consistent pattern of noncompliance by the Delegated Entity, the Audit & Oversight Department will conduct a focused review. If the results of the focused review are unfavorable, the Auditor will escalate to the AOC for further actions." **MONITORING/OVERSIGHT** - "Delegation Oversight Dashboard" (Review period 03/01/22 – 08/31/22) this dashboard information is collected

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	4. A&O reached out to Kaiser, and they ensured acknowledgement letters will be sent to members within 5 calendar days. Kaiser indicated that the case processing staff were coach/counseled on November 16, 2022 (Attachment 5). Kaiser has also indicated that the following mitigation controls have been implemented: a. Daily: The Kaiser Grievance management team monitors and views daily reports/dashboard in Tableau (Attachment 6) in order to engage the case processing, staff to ensure compliance with due dates. The reports indicate upcoming due dates of letters and case/resolution. b. Quarterly: The management, leadership and Kaiser's national compliance team reviews a quarterly report that monitors for acknowledgement timeframes and case quality (Attachment 7). If the report indicates non-compliance, it also demonstrates root cause analysis, and any improvement efforts made to meet compliance.	4.1.3_Attachment 5_ 2022 DHCS CalOPTIMA Attestation 4.1.2_Attachment 6_CA_HI Open _Acknowledgement Dashboard_redacted 4.1.3_Attachment 7_Q2 2022 Medicaid Health Plan Compliance Metrics Dashboard Appeals and Grievances_redactedV3		on a quarterly basis from the delegate to confirm that grievance acknowledgement letters are being sent within the required timeframe of five calendar days. - Dashboard Report, "Q2 2022 Medicaid Health Plan Compliance Metrics Dashboard FINAL" (10/18/22) demonstrates MCP is monitoring quarterly for acknowledgement letter timeframes. If non-compliance is shown, the MCP will provide a root cause analysis and any efforts to improve in order to be compliant. - Daily Report, "Open Inventory Detail Report" (as of 11/16/22) demonstrates the MCP is monitoring when grievances are received and when acknowledgement is due within five calendar days as required. - Audit Report, "CalOptima Health Plan Quarterly Report" (Q4 2022) demonstrates that the MCP has a monitoring process to track and trend standard grievance acknowledgement letter dates to identify reoccurring issues. Out of the 337 cases reviewed,

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				90% were compliant with the standard acknowledgement letters being sent to members within 5 calendar days. - Audit Tools, “2022 Readiness/Annual Assessment Grievance” and “2022 File Review Medi-Cal Grievances,” which timely issuance is monitored through the acknowledgement timeframe. Auditors consider the acknowledgement timeframes met when the letter is mailed out. Therefore, the five-calendar day timeframe includes the letter being mailed. **DELEGATE REVIEW** - Email shared with the delegate’s Senior Case Managers regarding cases where the acknowledgement letters were issued past the five days of receipt of the grievance. Per the MCP, the delegate demonstrated acknowledgement letters will be sent to members within five calendar days and the delegate has trained case processing staff of this requirement on November 16, 2022.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				The corrective action plan for finding 4.1.3 is accepted.
4.1.6 The Plan did not ensure that all medical quality of care grievances were referred to the Medical Director for review. The declined quality of care grievances were closed by customer service representatives without a Medical Director review.	In response to the finding, to ensure that all medical quality of care grievances are referred to a Medical Director for review, the Plan respectfully notes the following remediation efforts: **1. Policy Update** September 1, 2022: The Plan's Customer Service (CS) department updated CalOptima Health's policy DD.2013 Customer Service Grievance Process to include language that all potential quality of care declined grievances would be forwarded to the Plan's Quality Improvement (QI) department for review (Attachment 1). **2. Process Development** October 5, 2022: The QI department developed a process to ensure potential quality of care (PQOC) declined grievances are referred to the Medical Director for review as appropriate. The DTP was created on October 5, 2022, and further revised on December 1, 2022 (Attachment 2).	4.1.6_Attachment 1_DD.2013 - Customer Service Grievance Process_09-01-22 4.1.6_Attachment 2_ QI_DTP Declined Grievances 4.1.6_ Attachment 3_ Potential Quality of Care Declined Grievance DTP 4.1.6_ Attachment 4_PQOC Declined	1. September 1, 2022 2. October 5, 2022 October 14, 2022	The following documentation supports the MCP's efforts to correct this finding: **POLCIES & PROCEDURES** The MCP submitted revised P&P, DD 2013, "Customer Service Grievance Process" (09/01/22) to include that all Potential Quality of Care (PQOC) declined grievances are to be reviewed by the Medical Director. - Desktop Procedure, "Declined Grievances" (effective 10/05/22 and revised 12/01/22) this newly developed process by the QI Department describes when a declined grievance is received and forwarded to the Medical Director for review. - Desktop Procedure, "Potential Quality of Care Declined Grievances" (eff 10/14/22) recently developed process

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	October 14, 2022: The CS department developed a process to ensure PQOC declined grievances are referred to the QI department for Medical Director review as appropriate (Attachment 3). **3. Staff Trainings** The QI and CS departments conducted department trainings on this process. The CS department training occurred on October 13 and October 18, 2022 (make up session) (Attachments 4, and 5). The QI department training occurred on October 12, 2022 (Attachments 4 and 6).	Grievance Training (CS & QI) 4.1.6_ Attachment 5_PQOC Staff Training Sign-In Sheet (CS) 4.1.6_Attachment 6_Attestation Declined Grievance Process (QI)	3. October 12, 13 and 18, 2022	describes the Customer Services Department process for identifying, documenting, and routing a member's PQOC declined grievance issues to the QI Department's Medical Director for review. **MONITORING/OVERSIGHT** - Monitoring Process, "Monitoring Procedure for Miscategorized PQOC Grievances" (10/18/22) demonstrates the steps for addressing PQOC grievances and for ensuring a review of these cases is completed by the Medical Director in the QI Department. - Audit Tool, "PQOC Audit Tool", (05/22) demonstrates the Plan will audit monthly to monitor if a CSR missed a PQOC and if so, the CSR's Supervisor is informed to review/correct/coach and then will forward to Medical Director in the QI Department. - Audit Results, "Internal Customer Service Audit Results" (10/22, 11/22, 12/22, and 01/23) demonstrates the Plan is auditing monthly of declined

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				PQOC grievances and is making certain that declined PQOC grievances are being forwarded to the Medical Director in the QI Department. Out of 114 cases audited, the compliancy rate is 89%. **TRAINING** - Customer Service Training and attestation log (10/13/22 & 10/18/22). This training was conducted for Customer Service staff to review the process for identifying, documenting, and routing a member's PQOC declined grievance issues to the QI Department's Medical Director for review. - Quality Improvement Department Training and attestation log (10/1/22). This training was conducted for Quality Improvement staff to review the process for identifying, documenting, and routing a member's PQOC declined grievance issues to the QI Department's Medical Director for review.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				The corrective action plan for Finding 4.1.6 is accepted.
5. Quality Management				
5.1.1 The Plan's Quality Improvement Committee (QIC) did not ensure that members received appropriate and quality care by monitoring and evaluating the timeliness of clinical care and services provided to members. Problems identified in Utilization Management (UM) were not discussed in the UM Committee and escalated to QIC. The Plan's Quality Improvement Committee did not review UM activities to ensure members'	In response to the finding, to ensure the Plan's Quality Improvement Committee (QIC) monitors and evaluates the timeliness of clinical care and services provided to members, the Plan respectfully notes the following remediation efforts: 1. The Plan developed a QIC Prep workflow (Attachment 1) to ensure all committees that report to QIC are involved in a prep meeting prior to QIC to ensure all non-compliance issues are discussed and added to the meeting agenda. 2. Before each QIC meeting, a preparation meeting (Attachment 2) will be held with all presenters. QI staff will request from attendees if any identified problems, issues, and/or non-compliance need to be reported and/or escalated to the next QIC. 3. QIC presentation template (Attachment 3) will include a "Compliance Slide" within the meeting to present any previously identified problems, issues and/or noncompliance.	5.1.1_Attachment 1_QIC Prep Workflow 5.1.1_Attachment 2_QIC Prep Agenda Template 5.1.1_Attachment 3_QIC 11.08.22 PPT Template	1. November 17, 2022 2. November 2, 2022 3. November 8, 2022 4. November 17, 2022	The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** Attachment 4_QIC Charter 2022_QIC (Approved 12.13.22) The Plan submitted a Quality Improvement Committee (QIC) charter which includes the Utilization Management Committee (UMMC) which meets at least eight [8] times per year. The UM Committee is required to report quarterly to the QIC with clinical, quality, and patient safety studies (Page 1) Attachment 1_QIC Prep Workflow (Approved 12/13/22) The Plan submitted a new workflow that outlines the new pre-QIC Preparation Meeting procedure.

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timely access to care was not delayed for any reason. Delays in UM prior authorizations were not escalated to the QIC.	This slide will also be used to remind the committee participants to report any identified problems, issues and/or noncompliance the next QIC. 4. The Plan will ensure a Quality Improvement (QI) representative attends the Utilization Management Committee (UMC) and other committee quarterly meetings (Attachment 1). This will ensure that identified problems, issues and/or noncompliance are reported and/or escalated to QIC. 5. In preparation of the QIC meeting, QI staff will reach out to Utilization Management (UM) and other department leadership to confirm if there are problems, issues and/or identified noncompliance that should be reported/escalated to QIC (Attachment 1). 6. The Plan has updated the QIC Charter, to indicate that the Utilization Management Committee will report to QIC on a quarterly basis (page 3) (Attachment 4).	5.1.1_Attachment 4_QIC Charter 2022_QIC Approved 12.13.22	5. November 17, 2022 6. December 13, 2022	A QI representative attends UM Committee meetings to report identified problems, issues, and/or noncompliance areas to the QIC QIC staff also solicit UM leads to follow-up with flagged non-compliance issues. **MONITORING & OVERSIGHT** QIC Preparation Meetings Before each QIC meeting, a preparation meeting is held where emergent non-compliance issues are reviewed and added to the agenda. Compliance issues are discussed in the standing “Compliance” section (Slides 5-7) in the QIC Presentation Template (Attachment 3) See sample agenda – Attachment 2 QIC eBinder for 12/13/22 QIC Meeting and 2023 QIC Meeting Schedule (Attachments 5 & 6) As requested by DHCS, the Plan submitted evidence of implementation via their 12/13/22 QIC meeting as well as a schedule of meetings Any problems discussed in the UM committee (including prior

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				authorization) are indeed able to be brought up, discussed, and documented in QIC meetings (slide 40) **The corrective action plan for Finding 5.1.1 is accepted.**

Submitted by CalOptima Health: **Date:** 12/21/2022
Title: Chief Executive Officer