



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

CMAA Site Visit Summary of Findings
(Sample)



EDMUND G. BROWN JR.
GOVERNOR

(Today's Date)

(MAA Coordinator's Name)
(Title i.e. MAA/TCM Coordinator)
(Address)
(City, State, Zip Code)

Dear Ms/Mr. (MAA Coordinator's Last Name):

This letter is to provide you with our findings as to the Department of Health Care Services (DHCS), County-Based Medi-Cal Administrative Activities (CMAA) Site Visit (SV) on (Date of Site Visit).

The purpose of the CMAA SV was to verify that (Name of County) County was in compliance with the MAA participation requirements (i.e., the Provider Manual, Policy and Procedure Letters [PPLs], and the Centers for Medicare and Medicaid Services [CMS] letters).

The CMAA staff completed a comprehensive review of the following Claiming Units (CU) for the period of State Fiscal Years (Fiscal Years Under Review); (Fiscal Quarters Under Review):

- (Name of Claiming Unit Under Review)
- (Name of Claiming Unit Under Review)

Below are the detailed SV findings and what is required for (Name of County) County to complete their Corrective Action Plan (CAP) for the CU reviewed:

(Name of Claiming Unit Under Review)

FINDINGS: (SAMPLE) The DHCS CMAA Unit determined that the activities and functions of the (Name of Claiming Unit Under Review) are not claimable through the CMAA program because they are claimable through the CHDP Program.

CMAA Recommendations: (SAMPLE) (Name of County) County must delete this Claiming Unit from their Claiming Plan. Any pending or future invoices for this Claiming Unit will not be paid through the DHCS CMAA program. Since (Name of County) County had been previously paid for ineligible claims, (Name of County) County must return payment to the DHCS for the (Name of Claiming Unit Under Review) (Fiscal Year(s)); (Fiscal Quarter(s)) in the amount of (Total Amount of Repayment).

(MAA Coordinator's Name)

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(Today's Date)

CMAA Program Documentation Review Attendees:

DHCS CMAA Staff

- **(Full Name and Title of DHCS Staff Conducting the Site Visit)**
- **(Full Name and Title of DHCS Staff Conducting the Site Visit)**
- **(Full Name and Title of DHCS Staff Conducting the Site Visit)**

LGA Staff

- **(Full Name and Title of LGA Staff Member)**
- **(Full Name and Title of LGA Staff Member)**

LGA Interviewees:

- **(Full Name and Title of Claiming Unit Staff Member)**
- **(Full Name and Title of Claiming Unit Staff Member)**
- **(Full Name and Title of Claiming Unit Staff Member)**
- **(Full Name and Title of Claiming Unit Staff Member)**
- **(Full Name and Title of Claiming Unit Staff Member)**
- **(Full Name and Title of Claiming Unit Staff Member)**

Please provide the DHCS CMAA unit staff with a Corrective Action Plan within 30 days of receipt of this letter. If you have any questions concerning this CMAA Program Documentation Review, please contact **(Full Name of Analyst assigned to the LGA)**, Administrative Claiming Analyst of the CMAA Unit via telephone at **((916) xxx-xxxx)** or by e-mail at **(Analyst's Email Address @dhcs.ca.gov)**.

Sincerely,

(Full Name of the CMAA Unit Chief), Chief
County Based Medi-Cal Administrative Activities Unit