CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

November 2, 2023

Brandy Armenta, Compliance Director
Health Plan of San Mateo
801 Gateway Blvd, Suite 100
South San Francisco, CA 94080

RE: Department of Health Care Services Medical Audit

Dear Ms. Armenta:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Health Plan of San Mateo, a Managed Care Plan (MCP), from August 30, 2021 through September 10, 2021. The audit covered the period of November 1, 2019 through July 31, 2021.

The items were evaluated and 4 of 15 findings were repeat findings on the subsequent 2022 Medical Audit; therefore, DHCS will assess remediation for the 4 repeat findings in the 2022 Corrective Action Plan (CAP). As such, DHCS accepts and will provisionally close the 2021 CAP with findings 3.8.2, 5.2.1, 5.3.1, and 5.3.2 still needing remediation. The open findings are transferred to the 2022 CAP which has the same findings. The enclosed documents will serve as DHCS' final response to the MCP's 2021 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
Managed Care Quality and Monitoring Division
Department of Health Care Services

Enclosures: Attachment A (CAP Response Form)

cc: Stacy Nguyen, Chief
Managed Care Monitoring Branch
Managed Care Quality and Monitoring Division
Department of Health Care Services

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

Chengchoi Saelee, Contract Manager
Medi-Cal Managed Care Division
Department of Health Care Services

ATTACHMENT A
Corrective Action Plan Response Form

Plan: Health Plan of San Mateo **Review Period: 11/1/19 – 7/31/21**

Audit Type: Medical Audit and State Supported Services **CAP Submitted: 02/07/22**

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

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. The MCP shall directly address each deficiency component by completing the following columns provided for MCP response: 1. 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 confirm 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				
1.1.1 – Medical Director The Plan did not ensure that its CMO was a full-time physician.	The Plan has a full time CMO physician. The Plan has updated the UM Program description to include language the CMO is a full-time physician.	• 1.1.1 UM Program Description 2021 (*page 7 (B)*)	Completed	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • A revised 2021 UM Program Description that outlines the Chief Medical Officer's roles and responsibilities, addresses the requirement of full time status, and reporting requirement should there be a change. • The Chief Medical Officer oversees the Health Services Department and Quality Improvement Program. The Chief Medical Officer is the CEO's designee for the implementation of both the Quality Improvement (QI) and the UM programs. The Chief Medical Officer is responsible for ensuring that the Utilization Management program is properly developed, implemented, and coordinated. The CMO is also responsible for the evaluation, approval, and revision of the UM program. The CMO role is a full time position. • In a setting that the CMO is unavailable, they will delegate responsibilities to the Senior Medical Director. In a setting that the CMO vacates their position, an acting CMO will be appointed by the CEO to take on the responsibilities of the role. Should there be a change in the CMO, reporting to relevant regulatory agencies will occur based on compliance procedures. Verified with the Plan that they do employ a full time CMO (Dr. Esquerra) that was effective 5/3/21. **The corrective action plan for finding 1.1.1 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
1.1.2 - DHCS Notification of Changes in Status ofthe Medical Director The Plan did not report to DHCS the change in status of the CMO during the audit period within ten calendar days. They had a change in December 2019 as well as May 2021.	The Plan has updated the UM Program description to include language regarding notification to regulatory agencies when there is a CMO change. The Plan Human Resources department has included compliance on a distribution/notification list for all CMO changes.	• 1.1.1 UM Program Description 2021 (*page 7(D)*)	Completed	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • A revised 2021 UM Program Description that outlines the Chief Medical Officer's roles and responsibilities, addresses the requirement of full time status, and reporting requirement should there be a change. • The Chief Medical Officer oversees the Health Services Department and Quality Improvement Program. The Chief Medical Officer is the CEO's designee for the implementation of both the Quality Improvement (QI) and the UM programs. The Chief Medical Officer is responsible for ensuring that the Utilization Management program is properly developed, implemented, and coordinated. The CMO is also responsible for the evaluation, approval, and revision of the UM program. The CMO role is a full time position. • In a setting that the CMO is unavailable, they will delegate responsibilities to the Senior Medical Director. In a setting that the CMO vacates their position, an acting CMO will be appointed by the CEO to take on the responsibilities of the role. Should there be a change in the CMO, reporting to relevant regulatory agencies will occur based on compliance procedures. Verified with the Plan that they do employ a full time CMO (Dr. Esquerra) that was effective 5/3/21. **The corrective action plan for finding 1.1.2 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
1.2.1 - Medical Notice of Action(NOA) Letters The Plan did not ensure that NOA letters included clear and concise explanations of the decisions.	The Plan held re-training for CCS staff on NOA letters.	• 1.2.1 HEALTHsuite Letter Generator Review for Denials	Completed	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Procedure UM-DP revision date 2/4/22 details the MCP's denial letter audits of UM/UR nurses. The audits will be conducted on a monthly basis and will include the review denial language to confirm that it is easily understandable. **TRAINING** • CCS Denial Letter Training Presentation and training roster demonstrate the MCP instructed staff on using language that is clear and concise and understandable to the member in its denials. • The Plan conducted a CCS denial letter training for its staff. The training included a section on language understandability. The Plan updated its procedure UM-DP to detail the monthly audit of the Plan's denial letters. The audits will be conducted on a monthly basis. The Plan also submitted three months of NOA letter audits. The NOA letter audit criteria includes verifying the readability of the letter. **MONITORING AND OVERSIGHT** • Monthly denial letter audits from October, November and December 2021 demonstrate the MCP's internal auditing of its NOA letters to confirm clear and concise of its decision explanations is operational.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				The corrective action plan for finding 1.2.1 is accepted.
2. Case Management and Coordination of Care				
2.5.1 - Provision ofSpecialty Mental Health Services (SMHS) The Plan did not ensure the provisionof SMHS by the county MHP.	The Plan does not require referrals for SMHS services. Members can self-refer, providers can refer. Members are triaged by BHRS to determine mild to moderate or SMHS. SMHS is a carve out and the plan coordinates with BHRS.	• 2.5.1 HS-05 MC Mental Health and Substanc e Use Referral and Coordinat ionof Services (*Page 3-4 Coordinat ionof Care*) • 2.5.1 CC-01 Care Coordinationand Case Management Program (*page 4*	Completed	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • "HS-05: Medi-Cal Mental Health and Substance use Disorder Services Referral and Coordination of Services" which explains the MCP's procedure on monitoring on member referrals. Referral monitoring and oversight will occur quarterly or more frequently as needed. Monitoring will include but are not limited to the areas of referrals to and from Behavioral Health and Recovery Services, Grievances and appeals concerning non-Specialty related services, and ACCESS Call Center statistics. The MCP's Chief Medical Officer or designee will be responsible for reviewing BHRS reporting (HS-05 MC MH Sub Use Referral and CoS, Page 4, Section 4.3). **MONITORING AND OVERSIGHT** • "Call Center and PCI Report" and "Call Center and PCI Analysis with Graphs" as evidence that the MCP monitors referrals made by the member or provider. The MCP generates reports monthly on referrals. The reports are analyzed and reviewed at the quarterly committee meeting (CC PCI Report, CC PCI Analysis).

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

				• Written response by the MCP (11/07/22) which demonstrates how the MCP meets the requirement in APL 18-015, Attachment 2, Section 5. Care Coordination (d):
				  • HPSM holds twice yearly Joint operations meetings to review issues and trends.
				  • HPSM meets on a quarterly basis with the leadership of each BHRS area- Adult services, Youth services and SUD services. All members that require care coordination are discussed as needed.
				  • HPSM and BHRS continue to engage in care coordination as needed by initiating IDT's between BHRS and HPSM ICM staff.
				• Written response by the MCP (11/07/22) which demonstrates how the MCP meets the requirement in APL 18-015, Attachment 2, Section 7. Reporting and Quality Improvement Requirements (a)(b)(c).
				  • HPSM holds twice yearly Joint operations meetings to review issues and trends.
				  • HPSM has access to the BHRS record system. At any time the information needs to be accessed, HPSM staff can look up individual members and connect with their BHRS treatment teams or provider to confirm to coordinate care.
				  • BHRS or any member working with BHRS can contact the ICM team to request care coordination- this information is shared through quarterly meetings, our website and member handbook.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				The corrective action plan for finding 2.5.1 is accepted.
2.5.2 - Memorandumof Understanding (MOU) with the Mental Health Plan (MHP) The Plan's MOU with the county MHP did not meet all the requirements specified in APL 18-015.	The Plan submitted the MOU on 11/10/2021 to DHCS contract manager as a part of routine reporting. The Plan did not receive a request from DHCS to modify language in the MOU submitted. The APL allows for language to reside within the MOU and/or within P&P's.	• 2.5.2 HPSM-BHRS MOU • 2.5.2 CC-01 Care Coordinati onand Case Managem ent Program (*page 4 section 3.1.2; page 7 section 3.4.3; page 13 section 3.8.5*)	Completed	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • "Addendum to Memorandum of Understanding Between the Health Plan of San Mateo and the San Mateo County Mental Health Plan" (January 2021) which has been updated to include the dispute resolution process. • Disputes between the MCP and the San Mateo County Mental Health Plan (MHP) will be remedied in accordance with the Memorandum of Understanding and California Code of Regulations Title 9, Section 1850.505. • MHP's Assistant Director and the MCP's Director of Provider Network Development & Services will serve as liaisons for purposes of dispute resolution. Upon the request of either, the MHP liaison and the • MCP liaison will meet and confer within five (5) business days of identification problems requiring resolution at the management level. • If the liaisons are unable to reach a joint decision acceptable to both MHP and the MCP, a second level review may be initiated by either. Within two weeks from the date of the request for secondary review, the MCP's Chief Executive Officer and MHP's Director, or their designees, will meet to • reach a resolution.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				• If the MCP's Chief Executive Officer and MHP's Director, or their designees, cannot reach a resolution satisfactory to the MCP or MHP, either party may submit a request within thirty (30) calendar days of the attempted resolution to the Mental Health Services Division of the Department of Health • Care Services, in accordance with California Code of Regulations Title 9, Section 1850.505. • Both the MCP and MHP agree to provide services to any member during the dispute resolution process in accordance with California Code of Regulations Title 9, Section 1850.505(j). (MC_BHRS_MOU Addendum_ 1.1.2021, Page 5). • Updated P&P, "CC-07: Care Transition Process" which has been updated to include the discharge planning process. • When estimated discharge date is identified and member's discharge plan is developed, member's CT support needs are assessed prior to discharge per use of the Integrated Care Management Post Discharge Checklist (ICM Post D/C Checklist). Should member be experiencing one or more scenarios related to post d/c medical care and complex care needs, the member is referred to Integrated Care Management Team for CT support to include assessment of care management level of service needs (CC-07 Care Transitions, Page 3, Section 3.1.2.1). • "Amendment Number One to Addendum to the Memorandum of Understanding Between the Health Plan of San Mateo and the San Mateo County Mental Health Plan" (July 2022) in which the MCP has updated

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				the Requests for Resolution and Care Coordination sections to meet the requirements in APL 18-015 and Attachments 1 and 2. **MOU Update:** • APLs 18-009 and 18-015 relating to Memorandum of Understanding (MOU) requirements are both being retired. • APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities was released on 10/11/23. • The APL clarifies the intent of MOU requirements and contains templates with general provisions and templates tailored for certain programs. • MCPs will be required to make a good faith effort to execute MOUs with other parties by 1/1/24, 7/1/24, or 1/1/25 as outlined in the APL. **The corrective action plan for finding 2.5.2 is accepted.**
2.5.3 - Alcohol Misuse Screeningand Counseling (AMSC) The Plan did not have policies and procedures to ensure	The Plan has updated policy and procedure HS-05 page 4, 4.0 Oversight and monitoring. The Plan is also including the MRR review standards and toolthat has been utilized on an ongoing basis. The Plans provider manual includes information	• 2.5.3 HS-05 MC Mental Health and Substance Use Referral and	Completed	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated P&P, "HS-05:Medi-Cal Mental Health and Substance Abuse Disorder Services Referral and Coordination of Services" (06/06/22) has been updated to include the Plan confirms providers offer and document AMSC. The following procedures/methods are performed:

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
PCP documentation for alcohol misuse screening services.	for required medicalrecord documentation.	Coordinationof Services • 2.5.3 Compliance Statement -		○ Through site reviews/medical record review audits. ○ Through report monitoring (of no less than annual). • An Email (05/25/22) which includes an insert (Page 125) from the 2022 Provider Manual that describes the Primary Care Physician Rights and Responsibilities. One of the responsibilities of the PCPs is documenting alcohol misuse screening services. **MONITORING AND OVERSIGHT** • Audit Standards & Audit Tool (Department of Health Care Services, Managed Care Quality and Monitoring Division) “Medical Record Review Standards” and “Medical Record Review Tool” (2020) which the Plan states is utilizing on an ongoing basis. • The Audit Standards for AMSC is for PCP sites to measure, evaluate, assess, and make decisions. • The Audit Tool is utilized to confirm PCPs document medical records to confirm AMSC documentation is captured in the members’ medical record. **The corrective action plan for finding 2.5.3 is accepted.**
3. Access and Availability of Care				

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
3.1.1 - Extended Waiting Time for Appointments The Plan did not fully implement its policy to ensure that if appointment waiting times are extended, there must be documentation that a longer timeframe will not have a detrimental impact on the member's health.	The Plan has updated its policy and procedure PS 06-01 Timely Access and Network Adequacy to reflect actions taken by the plan.	• 3.1.1 PS 06-01 Timely Access and Network Adequacy (*page 5 section 3.0; page 7 section 6.0*)	Completed	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated P&P, "PS 06-01: Timely Access and Network Adequacy" (02/07/22) which demonstrates that the applicable wait time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Member. (PS 06-01, Page 7, Section 6.0). • Email by the MCP (2/14/22) in response to monitoring provider compliance with documentation requirements when an appointment is extended: • From our review of the data sources mentioned in the PS 06-01 excerpt, HPSM is aware from survey results that provider(s) who are part of large systems do not delay appointments, but rather they utilize other providers within the group to meet appointment access which negates the need for delay documentation. The methodology criteria in some surveys do not account for those solutions already in place within the large systems but the Plan is able to identify those. In the event of a true delay when an appointment is extended, the FSR nurse captures the information during MRR and, if prompted by a grievance, the PS team investigates further which could include requesting documentation. (02-14-22 MCP

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				Response). **MONITORING AND OVERSIGHT** • Updated P&P, "PS 06-01: Timely Access and Network Adequacy" (02/07/22) which demonstrates the MCP's process to monitor and address extended wait times for appointments. The MCP conducts reviews of the DMHC PAAS results, member complaint data and DHCS quarterly timely access survey results to identify and follow up with providers that warrant potential corrective action. The MCP also uses this information to determine priority areas for further provider network development. (PS 06-01, Page 7, Section 7.0). • Meeting Minutes, "Provider Grievance Sub Committee" (June 2021, March 2022, September 2022) which demonstrates the review of the MCP's grievance data through the Grievance and Appeals Reports by Provider. The Grievance and Appeals Report Review is a standing agenda item during each Provider Grievance Sub Committee meeting. (PGSC Meeting Minutes). • Reports, "Access to Specialty Care Report, Behavioral Health Network Adequacy Report, Timeliness of Services Report" (2021) which demonstrates the MCP's analyses on PAAS results. (Access to Specialty Care Report 2021, Behavioral Health Network Adequacy Report 2021, Timeliness of Services Report 2021). • "Network Hotspot Focus Study Letter and Questionnaire" (August 2021) and "Quarterly Monitoring Report Template" (Q2 2022) which demonstrates the MCP's review of Timely Access data. (Hotspot Letter

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				and Questionnaire, QMRT 2022 Q2_Responses). **The Corrective Action Plan for Finding 3.1.1 is accepted.**
3.8.1 - Non-Emergency Medical Transportation Prior Authorization The Plan did not subject non-COVID related NEMT services to prior authorization and did not require providers to use the PCS forms. The Plan did not determine the appropriate mode of transportation to meet members' medical needs.	The Plan lifted authorization requirements as allowed under the Public Health Emergency (PHE) which was during the audit review period. The Plan has updated policy and procedure UM-013 Non-Emergency Medi-Cal	• 3.8.1 UM.013 Non-Emergency Medical Transportation(*page 2 section 2.0; page 3 section 3.5; page 3 section 4.0*)	The PHE is stillin effect; however, the Plans goal is to reinstate prior authorization requirement by April 1, 2022. Long-Term.	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • **UM.013 NEMT** o The Plan will collect the completed PCS forms before NEMT services are provided. [Page 2, section 3.5]. o The Plan will not modify a PCS form once prescribed. [page 2, section 3.8] o Policy states NEMT is not medically necessary if the prior authorization requirements are not met [page 2, section 2.9]. o The Plan conducts quarterly oversight & monitoring to confirm NEMT providers are meeting all requirements in this policy & related APLs, & imposes corrective action if non-compliance is identified. [page 3, section 5.4] **MONITORING AND OVERSIGHT** • **NEMT Prior Auth Monitoring Sample** o The system used by the Plan intakes & scans authorizations, automatically rejects requests if the request doesn't meet the requirements outlined in written policies, including missing or

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				incomplete PCS forms. ○ The system generates a notification to the provider that the request was rejected with the reason why. ○ Plan staff monitor the rejected requests daily within the system & engage in provider outreach to obtain the missing information, including providing instructions. • **"Provider Notification NEMT PA Requirement"** ○ The notification outlined the reinstatement of the requirement of NEMT Prior Authorization – effective 09/01/2022. • **HPSM PCS Form** ○ The Plan has combined its PCS/Prior Authorization form into a 2-page document. This has been submitted & approved as of 05/11/2023. (see supporting documentation from 2022 CAP) **The corrective action plan for finding 3.8.1 is accepted.**
3.8.2 - Non-Emergency Medical Transportation Provider Enrollment The Plan did not ensure that NEMT providers				DHCS has identified that finding 3.8.2 was a repeat finding on the subsequent 2022 Medical Audit; therefore, DHCS will assess full remediation for the finding 3.8.2 in the 2022 Corrective Action Plan (CAP). The open finding is transferred to the subsequent CAP which has the same finding.

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complied with Medi-Cal screening and enrollment requirements.				
4. Member Rights				
4.1.1 - Quarterly Grievance Report The Plan did not submit to DHCS quarterly grievance and appeal reports forMedi-Cal grievances that exceeded the required 30 calendar day timeframe.	The Plan submits the quarterly grievance report on the specified DHCS template on a quarterly basis. The Plan is not allowed to modify the template and the template does not include grievances that exceed 30 calendar days.	4.1.1 DHCS Quarterly Grievance Report Template.	Complete	DHCS has determined the MCP has been submitting all required grievance reports to DHCS as required by the contract and applicable All-Plan Letters. **No corrective action is required.**
5. Quality Management				

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
5.2.1 - Ownership and Control Disclosure Reviews The Plan did not collect ownership and disclosure forms from seven of nine credentialing delegates. The Plan collected incomplete ownership and disclosure information from two of nine credentialing delegates.				DHCS has identified that finding 5.2.1 was a repeat finding on the subsequent 2022 Medical Audit; therefore, DHCS will assess full remediation for the finding 5.2.1 in the 2022 Corrective Action Plan (CAP). The open finding is transferred to the subsequent CAP which has the same finding.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
5.3.1 – Delegation of Provider Training The Plan did not specify provider training responsibilities in its written agreements with the delegated entities.	The Plan has included an amendment schedule of when agreements will be amended tocodify provider training language. Most of the providersare large systems with affiliated hospitals and the contracting process is not exclusive to one update rather all necessary changes based on negotiations. The amendment grid reflects various timeframesof contract execution by system. The Plan requires the delegated entities to utilize HPSM provider training deck. The Plan has included the required acknowledgement of receipt of provider training attestation.	• 5.3.1 Amendment schedule • 5.3.1 Provider Training - Regulatory 2020.08.11 5.3.1 Provider Training - Regulatory 2020 - Attestation	Amendment Long-Term as defined on schedule. Provider training deck and attestation completed.	DHCS has identified that finding 5.3.1 was a repeat finding on the subsequent 2022 Medical Audit; therefore, DHCS will assess full remediation for the finding 5.3.1 in the 2022 Corrective Action Plan (CAP). The open finding is transferred to the subsequent CAP which has the same finding.
5.3.2 - Provider Training The Plan did not ensure that all new network providers	In May 2020 the change in process was updated for directly credentialed vs delegated credentialing. The desk procedure	• 5.3.2 PS 01-03 Provider Training Procedure (*page 2*	Complete	DHCS has identified that finding 5.3.2 was a repeat finding on the subsequent 2022 Medical Audit; therefore, DHCS will assess full remediation for the finding 5.3.2 in the 2022 Corrective Action Plan (CAP). The open finding is transferred to the subsequent CAP which has the same finding.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
received training. ThePlan did not acquire provider training attestations or other documentation from providers who were part of delegated entities.	documentsthe annual audit process. The audit was completed in December and audit reports are being sent out the first week of February.	*section 1.5*) 5.3.2 Provider Training Monitoring - Desk Procedure		
6. Administrative and Organizational Capacity				
6.2.1 – Fraud and Abuse Reporting The Plan did not complete and report to DHCS the results of preliminary investigations of suspected fraud and abuse incidents within ten working days.	The Plan has updated its policy and procedure with the appropriate regulatory timeframes, so compliance staff is aware of the required timeframes for reporting.	• 6.2.1 CP.016 Investigating and ReportingFWA and Neglect 2022.02.07	Complete	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated P&P, "CP.016: Investigating and Reporting Fraud, Waste, Abuse and Neglect" (01/26/21) has been updated in accordance with the DHCS contract reporting timeframes for fraud, waste and abuse. **TRAINING** • Email (05/25/22) which includes a description of the informal training between the Compliance Manager and two auditors responsible for investigations and advised them of the reporting requirements under the contract, including the requirement to report to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days. **MONITORING AND OVERSIGHT**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				• Tracking Log, “Program Integrity Incident Tracking” (2021) which demonstrates internal monitoring to confirm the results of the preliminary investigation of suspected fraud and abuse incidents is sent to DHCS within 10 working days. • Email (05/18/22) The Plan has made the decision to disseminate PIU cases among its Compliance Auditors. **The corrective action plan for finding 6.2.1 is accepted.**
6.2.2 - Investigation of Suspected Fraud,Waste and Abuse The Plan did not conduct investigationsof all suspected fraud,waste, and abuse.	The Plan has updated it policy and procedure to reflect current operations for investigations of all suspected fraud, waste, and abuse.	• 6.2.2 CP-DP.002 FWA Incident Investigation and Reporting 2022.02.07	Complete	The following documentation supports the MCP’s efforts to correct this finding: **POLICIES AND PROCEDURES** • Desktop Policy & Procedure, “FWA Incident Investigation and Reporting” (02/07/22) as evidence that the Compliance Department staff is provided the necessary instructions to receive, investigate, report, and resolve FWA incidents. **TRAINING** • An email (05/25/22) provides a meeting description which is used in lieu of training. • Meeting, “Discuss Cotiviti/Nucleus” (03/02/22) which provides individualized training between the auditor who is responsible for monitoring and investigating Cotiviti referrals and contracted vendor.

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

				• Meetings, “Cotiviti Universal Discussion” (05-10-22) and “Cotiviti Investigation” (05-16-22) which provided dedicated training between the auditor and compliance manager related to Cotiviti.
				
				• In addition, the auditor meets regularly with the compliance manager to review Cotiviti referrals and discuss investigations. These meetings occur during regularly scheduled office hours or one on ones and are not specifically devoted to Cotiviti. During these sessions, the compliance manager has provided one-on-one training and guidance regarding:
				
				  • Using the Cotiviti platform
				  • Analyzing Cotiviti referrals
				  • Methods of Investigations
				  • Logging referrals and file maintenance
				  • Reporting requirements, including timeliness, and completing the MC 609 form
				
				MONITORING AND OVERSIGHT
				
				• Tracking Log, “Compliance Issue Tracking Log” (August, October, November, and December 2021) as evidence that the MCP is monitoring investigation status of FWA cases. The compliance manager is responsible for monitoring the log and is maintained by auditors on an ongoing basis. The log is periodically reviewed by the Compliance Committee.
				
				The corrective action plan for finding 6.2.2 is accepted.

Submitted by Plan: Pat Curran [Signature on File] **Date:** 02/07/2022

Title: Interim Chief Executive Officer