CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

April 7, 2025

Brandy Armenta, Compliance Director *Via E-mail*
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 July 25, 2022 through August 3, 2022. The audit covered the period from August 1, 2021, through June 30, 2022.

The items were evaluated, and DHCS accepted the MCP's submitted Corrective Action Plan (CAP). The CAP is hereby closed. The enclosed documents will serve as DHCS' final response to the MCP's CAP. Closure of this CAP does not halt any other processes in place between DHCS and the MCP regarding the deficiencies in the audit report or elsewhere, nor does it preclude the DHCS from taking additional actions it deems necessary regarding these deficiencies.

Please be advised that in accordance with Health & Safety Code Section 1380(h) and the Public Records Act, the final audit report and final CAP remediation document (final Attachment A) will be made available on the DHCS website and to the public upon request.

If you have any questions, please reach out to CAP Compliance personnel.

Sincerely,

[Signature on file]
Lyubov Poonka, Chief
Audit Monitoring Unit
Process Compliance Section
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

Enclosures: Attachment A (CAP Response Form)

cc: Bambi Cisneros, Interim Chief *Via E-mail*
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

Grace McGeough, Section Chief *Via E-mail*
Process Compliance Section
Managed Care Monitoring Branch
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

Joshua Hunter, Lead Analyst *Via E-mail*
Audit Monitoring Unit
Process Compliance Section
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

Nicole Cortez Unit Chief *Via E-mail*
Managed Care Contract Oversight Branch
DHCS – Managed Care Operations Division (MCOD)

Matthew Nabayan, Contract Manager *Via E-mail*
Managed Care Contract Oversight Branch
DHCS – Managed Care Operations Division (MCOD)

ATTACHMENT A

Corrective Action Plan Response Form

Plan: Health Plan of San Mateo (HPSM) **Review Period:** 8/1/2021 – 6/30/2022

Audit: Medical Audit and State Supported Services **On-site Review:** 7/25/2022 – 8/1/2022

MCPs are required to provide a Corrective Action Plan (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, which will reduce the turnaround time for DHCS to complete its review. According to ADA requirements, 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, as well as 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. Supporting Documentation, and 4. Completion/Expected Completion Date. The MCP must include a 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 details, such as the 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. Implementing deficiencies requiring short-term corrective action 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 remedy or operationalize completely, the MCP is to indicate that it has initiated remedial action and is on the way toward achieving an acceptable level of compliance. In those instances, the MCP must include the date when full compliance will be completed in addition to the above steps. Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval, as applicable, according to existing requirements.

Please note that 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 DHCS grants prior approval for an extended implementation effort.

DHCS will communicate closely with the MCP throughout the CAP process and provide technical assistance to confirm that the MCP offers sufficient documentation to correct deficiencies. Depending on the number and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates.

1. Utilization Management

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
1.2.1 - Medical NOA Letters: The Plan did not send fully translated NOA letters for prior authorization denials to members with a primary threshold language other than English. **Recommendation:** Develop and implement policy and procedures to ensure that NOA letters are fully translated, including any clinical information, into a member's threshold language.	1. HPSM implemented an expanded process to provide the clinical rationale in the Member's threshold language. 2. HPSM updated its applicable policies to reflect the expanded NOA letter translation process.	*1. Medi-Cal Fully Translated NOA Letter_Redacted* *2. A) UM.019 Medi-Cal NOA Letter Template Process 20230501* *B) PH.205 Translation Policy*	6/20/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Policy PH.205 Translation Procedures outlines the MCP's process for verify the quality of translated materials and its translation process through use of a translation vendor. (1.2.1 PH.205 Translation Policy) » Policy UM.019 Medi-Cal Notice of Action Template Process has been updated to require written notices to be fully translated including the clinical rationale. (1.2.1 UM.019 Medi-Cal NOA Letter Template Process 20230501) **IMPLEMENTATION** » Example of fully translated NOAs demonstrates that the MCP is fully translating its NOAs including the clinical rationale. (1.2.1 MC-NOA-(Denial)-664198 & 1.2.1 MC-NOA-(Modified)-663447) **The corrective action plan for finding 1.2.1 is accepted.**
1.3.1 - Written Consent from the Member for Appeals	1. HPSM implemented a weekly monitoring process to ensure appeals filed by a provider on behalf of a	*1. A) GA.08 Appeals Policy_v31*	4/27/2023	The following documentation supports the MCP's efforts to correct this finding:

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
Filed by a Provider: The Plan did not ensure that members' written consent was received when providers filed standard appeals on the members' behalf. **Recommendation:** Revise and implement policies and procedures to ensure the Plan receives written member consent for standard appeals when a provider files on behalf of a member.	member were processed only if and after member written consent was received. 2. Appropriate HPSM staff were trained on the requirements for obtaining member written consent.	*B) GA-DP.008 Monitoring of Provider Filed Appeals* *2. A) G&A Staff Mtg Agenda 2023.07.31* *B) G&A Staff Training Attendance List*		**POLICIES AND PROCEDURES** » Policy GA.08 Member Appeals Procedure updated to require written consent from the member to proceed with a provider-initiated appeal. (1.3.1 GA.08 Appeals Policy_v31) » GA-DP.008 Monitoring of Written Consent describes the process for obtaining member written consent and the monitoring on a weekly basis of open provider appeal cases. (1.3.1 GA-DP.008 Monitoring of Provider Filed Appeals 20230501). **TRAINING** » G&A Staff Meeting Agenda from 7/31/23 demonstrates the MCP has trained staff on the new process for appeals filed by providers on behalf of the member. (1.3.1 G&A Staff Mtg Agenda 2023.07.31) **IMPLEMENTATION** (From 2023 CAP) » Sample Case File demonstrates the MCP is requiring written consent from members to proceed with provider-initiated appeals. (1.3.1 Sample Case File 20240226) **MONITORING** (From 2023 CAP) » DP.008 Monitoring of Provider Filed Appeals documents the MCP's monitoring process to verify written consent is obtained for provider initiated appeals. On a weekly basis, a report is generated of all provider filed appeal cases awaiting written consent and resulting case notes. This is reviewed by the G&A supervisor. On a weekly basis, the G&A Supervisor will review the open provider-filed

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				appeals cases without written consent and follow up with individual staff members. (1.3.1 GA-DP.008 Monitoring of Provider Filed Appeals 20230501) **The corrective action plan for finding 1.3.1 is accepted.**

2. Case Management and Coordination of Care

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
2.1.1 - Provision of IHA: The Plan did not ensure the provision of a complete IHA to each new member. **Recommendation:** Implement policies and procedures to ensure the provision of a complete IHA to each new member within 120 calendar days of enrollment.	1. HPSM updated its Initial Health Appointment (IHA) policy to align with requirements outlined in APL 22-030. 2. HPSM implemented a new monitoring process for tracking IHA completion. 3. HPSM informed its network providers of IHA related changes, including the renaming of an IHA to Initial Health Appointment and the SHA being eliminated	1. *QI-107 Initial Health Appointment_v2023* 2. A) *IHA Quarterly Report Specifications* B) *IHA Quarterly Trend – PCP* 3. A) *Provider Notification_20230118* B) *P4P Training Webinar MY 2023_20230120* C) *Provider Newsletter March 2023_20230401*	2/27/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Plan Policy QI.107 Initial Health Appointment (2/27/23) has been revised to align with APL 22-030. Policy outlines IHA requirements and requires PCPs to perform an IHA with new members within 120 days of enrollment. » Outlines both member and provider informing materials, including: New member orientation EOC Member newsletters New member packets Plan website » Monitoring: QI Nurse conducts MRR audits every three years or as needed. IHA timeliness performance reviews are conducted quarterly and utilize claims and encounter data to capture IHA performance within 120 days of enrollment.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				Measure/monitor provision of all applicable preventive services based on age/condition through regular Managed Care Accountability Set and HEDIS reporting. Underperforming PCPs will be investigated and subject to focus MRR audits based on identified deficiencies. New Medi-Cal members receive welcome calls, which includes reminding the member to choose a PCP and establish care with an initial visit. **OVERSIGHT AND MONITORING** » Provider Notification (1/18/23) informed network providers of IHA related changes, including the renaming of an IHA to Initial Health Appointment and the SHA being eliminated. » Benchmark P4P program (Page 45) measures percentage of newly enrolled and/or assigned members who have had an IHA within 120 days of enrollment. » Monthly Active Engagement Reports help conduct outreach to newly enrolled members assigned to providers. Details include most recent ED visit and/or hospitalization, primary diagnosis, last primary care visit. » Plan monitors provider performance, IHA completion, panel engagement, quality metrics, allowing the Plan to identify low/high performing providers (IHA Quarterly Tracking/Trend

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				reports). IHA completion rates are tracked quarterly and trended over several quarters to account for variation. » PCPs can be identified for investigation in multiple ways, including trending low performance through quarterly IHA monitoring reports, a high rate of access-related grievances, a high rate of PCP change requests from their assigned members, investigation of a potential quality issue, etc. » March Provider Newsletter provides an update on new completion requirements for Initial Health Appointment. Directs providers to Plan's website to learn more about IHA, including elements providers need to address during an IHA, and new members assigned to their practice. **The corrective action plan for finding 2.1.1 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 - Telephone Call Wait Times: The Plan did not monitor members' waiting times for network providers to answer telephone calls. **Recommendation:** Develop and implement procedures to ensure that the wait times for answering telephone calls from members are monitored.	1. HPSM implemented a new monitoring process for measuring call-wait times into network provider offices.	1. A) *PS 06-01 Timely Access and Network Adequacy* B) *MY2023 PAAS PCP Raw Data Template for Survey Administration* C) *PAAS MY2022 Raw Data_PCP_Redacted*	8/15/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Updated P&P "3.1.1 PS 06-01 Timely Access and Network Adequacy_20230331" PS 06-01, Page 9, Section 6.3.3.3 "Phone wait times: HPSM will monitor wait times when calling a provider office. HPSM surveyor will measure the number of seconds between initiating the call and speaking to provider or office staff to collect appointment information, including any time in which surveyor is placed on hold. Survey will continue until a statistically significant sample of providers for each provider type is achieved. Plan will monitor results for compliance with a 300 second (5 minute) standard. Non-responding providers and those whose first call wait time exceeds the 5 minute standard will receive a follow-up call to re-survey within 5 business days. If the follow-up call again exceeds the standard, HPSM will notify provider of call wait time standard and their noncompliance. HPSM will then conduct a follow-up survey within 30 days of this notification." » Plan submitted updated template "3.1.1 MY2023 PAAS PCP Raw Data Template for Survey Administration" containing appended additional question for monitoring compliance for member's

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				waiting times to answer telephone calls. (3.1.1 MY2023 PAAS PCP Raw Data Template for Survey Administration, Cell AV 1) **MONITORING AND OVERSIGHT** » Tracking Tool "3.1.1 PAAS MY2022 Raw Data_PCP_Redacted" demonstrates the MCP's process to monitor and track telephone call wait times. MCP has stated PAAS surveys occur annually. HPSM will leverage DMHC's established PAAS methodology for calculating sample size. The MCP has also mentioned that to date, the MCP has since not had a provider to reach the point of needing a corrective action plan. Also, the MCP has appended an additional question to DMHC Provider Appointment Availability Survey instrument (PAAS). Plan will continue to collect and monitor this data for all included provider types at least once annually. » Manuals and Reports: The MCP has stated the PAAS occurs annually, and the MCP will leverage DMHC's established PAAS methodology for calculating sample size. ("3.1.1 PAAS Manual MY 2023" (Pages 10 and 40) and "3.1.1 PAAS Methodology MY 2019" (Pages 7 and 25). **The corrective action plan for finding 3.1.1 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
3.1.2 - Monitoring Access to First Prenatal Appointments: The Plan did not monitor the availability of first prenatal appointments. **Recommendation:** Revise and implement policy and procedures to ensure that the Plan monitors the access to and availability of first prenatal appointments.	1. HPSM updated its Provider Appointment Availability Survey (PAAS) methodology to measure OB/GYN network providers, in totality, against timely access standards.	1. A) *PS 06-01 Timely Access and Network Adequacy* B) *Network Timely Access Assessments DTP* C) *MY2022 OBGYN Appointment Monitoring Results*	6/20/2023	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" (03/31/23) which outlines the MCP's monitoring process. The time between the date/time of first next available appointment reported by OB/GYN respondents and the date/time of survey completion will be assessed against a 10-business day standard. Providers who report non-compliance with the standard will receive a formal notification of their non-compliance with the standard and an advisory that they will be surveyed again at an unspecified time within 90 days. Providers who report non-compliance with the standard on, or who are non-responsive to, the second attempt will be placed on a corrective action plan. (PS 06-01 Timely Access and Network Adequacy). » Desktop Procedure, "Network Timely Access Assessments" to demonstrate that the MCP conducts the Provider Appointment Availability Survey (PAAS) annually to assess first next available urgent and routine appointments, and includes OB/GYN as a provider type for the data collection process. (Network Timely Access Assessments DTP). **MONITORING & OVERSIGHT**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				» "MY2022 OBGYN Appointment Monitoring Results" to demonstrate that the MCP is annually monitoring the availability of first prenatal appointments. The monitoring results tracks the Provider Survey Type: OB/GYN, Date Survey Completed, the next available appointment date for an urgent appointment, and a non-urgent appointment, and the next available appointment date after the first appointment. (MY2022 OBGYN Appointment Monitoring Results). **The corrective action plan for finding 3.1.2 accepted.**
3.8.1 - NEMT Prior Authorization Process: The Plan did not implement a prior authorization process or require providers to use PCS forms prior to providing NEMT services. **Recommendation:** Develop and implement policy and procedures to	1. HPSM reinstated prior authorization (PA) and physician certification statement (PCS) form requirements for its NEMT benefit.	1. A) *UM.013 Non-Emergency Medical Transportation_rev8* B) *HPSM Approval - PCS Form*	9/1/2022	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** UM.013 NEMT » The Plan will collect the completed PCS forms before NEMT services are provided. [Page 2, section 3.5]. » The Plan will not modify a PCS form once prescribed. [page 2, section 3.8] » Policy states NEMT is not medically necessary if the prior authorization requirements are not met [page 2, section 2.9]. » The Plan conducts quarterly oversight & monitoring to demonstrate NEMT providers are meeting all requirements in this

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
ensure NEMT services are subject to a prior authorization process that includes PCS forms.				policy & related APLs, & imposes corrective action if non-compliance is identified. [page 3, section 5.4] **OVERSIGHT AND MONITORING** NEMT Prior Auth Monitoring Sample » 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 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. **The corrective action plan for finding 3.8.1 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
3.8.2 - NEMT Medi-Cal Enrollment: The Plan did not ensure NEMT providers were enrolled in the Medi-Cal program. **Recommendation:** Revise and implement policy and procedures to ensure all NEMT providers are screened, and enrolled in Medi-Cal prior to providing NEMT services.	1. HPSM updated its NEMT policies to require Medi-Cal enrollment of its transportation providers, language to enforce non-compliance, and its process for monitoring Medi-Cal enrollment.	1. A) *UM.013 Non-Emergency Medical Transportation_rev8* B) *CACTUS Credentialing File Review - Monitoring Report DTP* C) *NEMT Enrollment Tracker 2023.05.26* D) *NEMT Provider Roster_20220130*	9/20/2022	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Plan policy "UM.013 NEMT" demonstrates the Plan will require providers to be enrolled in Medi-Cal. All providers are required to be enrolled no later than 120 days. For providers with a pending application, the Plan will track the 120-day timeframe through its NEMT Provider Roster. (UM.013, section 4.3, page 3) **OVERSIGHT AND MONITORING** » Plan policy "UM.013 NEMT" demonstrates the Plan conducts quarterly monitoring & oversight of NEMT providers & imposes corrective action if non-compliance is identified. (UM.013, section 5.0, page 3) "NEMT Provider Roster_20230130" » The roster demonstrates all transportation providers are enrolled, pending within 120 days, and/or have been terminated. The Plan's transportation roster has been approved by the MCQMD Transportation SME.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				» This roster is cross-checked against the PAVE system on a weekly basis to confirm Medi-Cal enrollment at the time of contracting. (See CACTUS Credentialing File Review – Monitoring Report DTP) **The corrective action plan for finding 3.8.2 is accepted.**

4. Member's Rights

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
4.1.1 - Grievance Resolution Timeframe: The Plan did not resolve standard grievances within the timeframe of 30 calendar days. **Recommendation:** Implement policy and procedure to ensure standard grievances are resolved within 30 calendar days.	1. HPSM implemented a weekly monitoring process to ensure standard grievances are resolved within the timeframe of 30 calendar days. 2. HPSM Grievance and Appeal staff were re-trained on grievance timeframe requirements.	1. A) *GA-DP.001_Monitoring of Timeliness of G&A Cases* B) *MC Dashboard December 2022 - G&A* 2. A) *GA.07 Grievance Policy* B) *G&A Staff Training Attendance List_20221003*	10/3/2022	The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** » Desktop Procedure, "Monitoring of Timeliness of G&A Cases" (02/27/23) demonstrates the Plan has created the steps for ongoing monitoring of the timeliness of G&A cases at an individual staff level. The Chief Health Officer is responsible for overseeing the performance of the Grievance and Appeals Department, ensuring that the department is in compliance with all regulatory standards. » On a daily basis, the G&A Supervisor will review the open cases and follow up with individual staff members if their cases will be due within the next 3 days to demonstrate they will be closed prior to the due date. » On a weekly basis, a report is generated of all open cases with due dates for the upcoming week. This list is reviewed at each staff meeting which is held at the beginning of each week. » On a monthly basis, a compliance dashboard is created and reviewed by the Chief Health Officer to allow for trending of timeliness performance over time **MONITORING & OVERSIGHT**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				» Dashboard, "Grievance, Standard Written Notification Timeliness" (12/22) The dashboard metrics reflect all G&A cases that reached resolution in that reporting month. Dashes or blank cells indicate zero cases for that metric.100% compliant. » Dashboard, "Grievance, Standard Written Notification Timeliness" (01/23, 02/23, and 03/23) Demonstrates the Plan has effective monitoring to confirm all standard grievances are resolved within the timeframe of 30 calendar days. » Report, "Grievance Weekly Cases Due" (04/23, and 05/23) This report is generated weekly of all open cases with due dates for the upcoming week. This report pulls data from our grievance and appeals management system to identify all cases that are due that week. The Grievance and Appeals Supervisor reviews the report to identify 1) all cases due that week and 2) follows up with any coordinators that have been assigned cases that will be due within the next 3 days. » Written Statement, (03/23) The Plan states, "In the interim, consultants were brought on as SMEs to review all G&A cases and consult with staff on process, best practices, questions, requirements, etc. Their involvement would apply to all G&A matters in this CAP."

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				» Workflow, "Grievances and Appeals" (02/03/23) demonstrates the Plan had a change in the executive leadership. The G&A Department now reports to the Chief Health Officer. **TRAINING** » Review of P&P GA.07, "Member Grievance Procedure for Medi-Cal" demonstrates new staff were hired and given appropriate grievance process training during onboarding. These policies were provided in supplement, to reiterate a focus on the specific language of the requirements » Attestations, "Staff Training Attendance List" (10/03/22) evidence that the new staff received the above grievance process training. **The corrective action plan for finding 4.1.1 accepted.**
4.1.2 - Written Notification of Delay: The Plan did not notify the members in writing of the status of their grievances and the estimated date of resolution when the	1. HPSM implemented a weekly monitoring process to ensure standard grievances are resolved within the timeframe of 30 calendar days. 2. HPSM Grievance and Appeal staff were re-trained on grievance timeframe requirements.	1. A*) GA-DP.001_Monitoring of Timeliness of G&A Cases* B) *MC Dashboard December 2022 - G&A*	10/3/2022	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Desk Top Procedure, "Monitoring of Timeliness of G&A Cases" (02/27/23) demonstrates the Plan has created the steps for ongoing monitoring of the timeliness of G&A cases at an individual staff level.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
resolution was not reached within 30 calendar days. **Recommendation:** Implement policy and procedure to ensure members receive in writing, the status of their grievance and the estimated date of resolution when the resolution exceeds the 30 calendar day timeframe.		C) *Grievances _Weekly Cases Due 20230501* D) *Grievances - Timeliness Report 2023 Q1* 2. A) *GA.07 Grievance Policy* B*) G&A Staff Training Attendance List_20221003* C) *G&A Staff Mtg Notes 2023.02.13*		» The Chief Health Officer is responsible for overseeing the performance of the Grievance and Appeals Department, ensuring that the department is in compliance with all regulatory standards. » On a daily basis, the G&A Supervisor will review the open cases and follow up with individual staff members if their cases will be due within the next 3 days to demonstrate they will be closed prior to the due date. » On a weekly basis, a report is generated of all open cases with due dates for the upcoming week. This list is reviewed at each staff meeting which is held at the beginning of each week. » On a monthly basis, a compliance dashboard is created and reviewed by the Chief Health Officer to allow for trending of timeliness performance over time. **MONITORING AND OVERSIGHT** » Report, "Weekly Cases Due" (04/23, 05/23, and 06/23) Demonstrates the Plan has a monitoring process, this report is generated of all open cases with due dates for the upcoming week. This report pulls data from our grievance and appeals management system to identify all cases that are due that week. The Grievance and Appeals Supervisor reviews the report to identify 1) all cases due that week and 2) follows up with any coordinators that have been assigned cases that will be due within the next 3 days.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				» Dashboard, "Grievance, Standard Written Notification Timeliness" (01/23, 02/23, and 03/23) demonstrates the Plan has effective monitoring to demonstrate notification is sent to members in writing of the status of their grievances and the estimated date of resolution when the resolution was not reached within 30 calendar days. » Report, "Grievances Timeliness Report" (Q1 2023) Column O in this report affirms that there have been no cases in 2023 that have gone beyond the 30-day timeliness requirement; as a result, we have no evidence of member notifications to provide. » Written Statement, (03/23) The Plan states, "In the interim, consultants were brought on as SMEs to review all G&A cases and consult with staff on process, best practices, questions, requirements, etc. Their involvement would apply to all G&A matters in this CAP." » Workflow, "Grievances and Appeals" (02/03/23) Demonstrates the Plan had a change in the executive leadership. The G&A Department now reports to the Chief Health Officer. **TRAINING** » Review of P&P GA.07, "Member Grievance Procedure for Medi-Cal" demonstrates new staff were hired and given appropriate grievance process training during onboarding. These policies were

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				provided in supplement, to reiterate a focus on the specific language of the requirements » Attestations, "Staff Training Attendance List" (10/03/22) evidence that the new staff received the above grievance process training. » Meeting Agenda, "Grievance and Appeal Staff Meeting Agenda" (02/13/23) demonstrates the Plan met with G&A staff to discuss untimely cases – in rare and unusual circumstances, if a case cannot be closed within 30 days, a written notification letter needs to be sent to the member before day 30. Members also need to be informed before day 30. Please call the member to notify of delays prior to day 30 and letter going out. **The corrective action plan for finding 4.1.2 is accepted**

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 ensure that its subcontractors submitted complete ownership and control disclosure information. **Recommendation:** Develop and implement policies and procedures to ensure complete collection of all subcontractors' ownership and control disclosure information.	1. HPSM worked with its delegated providers to obtain updated Ownership & Control Forms.		4/15/2024	The Plan must continue to ensure subcontractors accurately provide all required information in their disclosures. Additionally, the Plan must review disclosure forms to identify potential conflicts of interest and make subcontractor ownership and control disclosures available upon request, as the information is subject to audit by DHCS." For additional DHCS guidance refer to DHCS/MACC e-mail 4/15/24. **The corrective action plan for finding 5.2.1 is accepted.**
5.3.1 - Delegation of Provider Training:	Please see Supporting Documentation.	5.3.1 Magellan Health Inc	Long Term	The following documentation supports the MCP's efforts to correct this finding:

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
The Plan did not specify provider training responsibilities in its written agreements with subcontractors. **Recommendation:** Revise and implement delegated agreements to include and specify all delegated activities and responsibilities of the subcontractors.		Amend 9 20240226		**POLICIES AND PROCEDURES** » Plan policy, "Health Plan of San Mateo Policy & Procedure Manual" PS.01-03, Provider Training (revised 5/16/2022), outlines the procedures already in place that the Plan is to provide Medi-Cal Program Overview New Provider Training materials to delegated credentialing provider groups to incorporate into their new provider onboarding process. Training must be conducted within the required timeframe of providing the training within ten working days and completion within 30 calendar days of becoming an active provider with the group. (PS 01-03 Provider Training, Page 2, Section 1.3) » The Plan submitted revised Provider Training Executed Amendments, which have been updated to contain language on provider training as a responsibility for the subcontractors, for the following: Sutter Health, Dignity Health Medical Foundation, University Healthcare Alliance, Magellan Health, Inc., Stanford Hospital and Clinics, San Mateo Medical Center, University of California, San Francisco, and Lucile Packard Children's Hospital Medical Group. **TRAINING** » Plan policy, "Health Plan of San Mateo Policy & Procedure Manual" PS.01-03, Provider Training (revised 5/16/2022) demonstrates that the P&P requires a Designated Training Contact who oversees completion of training. Delegated entities are to report training completion dates as requested and no less frequently than twice

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				annually. Providers are required to complete an "Acknowledgement of Receipt of Training" form, signed by the provider or a designated staff person at the provider's practice, within 10 working days of becoming an active provider. This documentation is retained by the provider/designee with the training completion date(s). (PS 01-03 Provider Training, Pages 1 & 2, Section 1.0, sub-sections 1.2.1-1.2.3) **MONITORING AND OVERSIGHT** » The Plan developed and implemented "Delegate Provider Training Report", a tracking tool to maintain ongoing compliance with subcontractors' New Provider Training. Delegated entities are to report training completion dates as requested and no less frequently than twice annually. (5.3.1 Delegated Provider Training Report Tracker 20240610) » The Plan's policy states that providers who are non-compliant with the New Provider Training requirement are subject to corrective action and escalation to the Plan's peer review committee. (PS 01-03 Provider Training, Page 2, Section 1.5.2) » Provider Training Report" (April 2024) to demonstrate that SMMC and Magellan has submitted their Provider Training Report to the Plan. (SMMC Medi-Cal Provider Training Report, Magellan Provider Training Report) » "Provider Training Report" (April 2024 – October 2024) to demonstrate that Dignity, Stanford (SHC/LPCH/UHA), Sutter/PAMF,

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				and UCSF has submitted their Provider Training Report to the Plan. (Provider Training Report – Dignity, Provider Training Report Stanford, Provider Training Report Sutter PAMF, Provider Training Report - UCSF) **The corrective action plan for finding 5.3.1 is accepted.**
5.3.2 - Provider Training: The Plan did not ensure that all network providers received new provider training. **Recommendation:** Implement procedures to ensure that all network providers receive provider training.	1. HPSM distributed provider notifications regarding updated Provider Training requirements comprised of: a. Processes for onboarding and administering of trainings; b. Mechanism(s) for provider groups to monitor provider training timeliness; and c. Requirements to submit to HPSM, twice annually, provider training reports. 2. HPSM created an annual audit process to validate that applicable provider groups adhere to provider training requirements. 3. HPSM updated plan policy and desk-level procedure to codify	1. *Medi-Cal new provider training reports #nonsec#* 2. *Template - HPSM Provider Training Audit Letter* 3. *PS 01-03 Provider Training Delegate Provider Training Attestation and Reporting*	1. As follows: a. 10/26/2022 b. 10/26/2022 c. 01/01/2023 2. 12/29/2022 5/12/2022	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCIEDURES** » The Plan's policy, "PS 01-03: Provider Training," (5/16/22) states that providers who are non-compliant with the New Provider Training requirement are subject to corrective action and escalation to the Plan's peer review committee. (PS 01-03 Provider Training, Page 2, Section 1.5.2). » Email, "Medi-Cal New Provider Training Reports" (10/26/22) to demonstrate that the Plan requested to their network that attestations and reports be sent to them biannually no later than April 15th and October 15th while reminding representatives of provider requirements. The Plan included a reminder of their annual internal audit process wherein a random sample of new providers will be reviewed. (Medi-Cal New Provider Training Reports). » Desktop Procedure, "Delegated Provider Training Attestation and Reporting" which states that during the report and attestation request process, a reminder email will be sent to the delegates 3-7

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	updated provider training requirements including oversight and monitoring, reporting, and enforcement escalation processes when non-compliance is identified.			days prior to the initial due date if no response. If delegates remain non-responsive, 2 more reminder emails will be sent on a weekly basis thereafter. After the 3rd reminder email, HPSM will reach out via email requesting a virtual meeting to support the delegates. If delegates are non-responsive, HPSM will pursue a corrective action plan with the delegates. (Delegate Provider Training Report and Attestation Desktop Procedure, Page 1, Section 2). **MONITORING AND OVERSIGHT** » The Plan's policy, "PS 01-03 Provider Training" (5/16/22) to demonstrate that the P&P requires a Designated Training Contact who oversees completion of training. Delegated entities are to report training completion dates as requested and no less frequently than twice annually. Non-compliant providers are subject to corrective action and escalation to the Plan's peer review committee. (PS 01-03 Provider Training, Page 2, Section 1.5.1.2). » Letter Template, "HPSM Provider Training Audit Letter" to demonstrate that the Plan submitted a template provider-facing letter outlining HPSM's oversight and collection of random provider samples for review. (Template - HPSM Provider Training Audit Letter). » "Provider Training Report" (April 2024) to demonstrate that SMMC and Magellan has submitted their Provider Training Report to the

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				Plan. (SMMC Medi-Cal Provider Training Report, Magellan Provider Training Report). » "Provider Training Report" (April 2024 – October 2024) to demonstrate that Dignity, Stanford (SHC/LPCH/UHA), Sutter/PAMF, and UCSF has submitted their Provider Training Report to the Plan. (Provider Training Report – Dignity, Provider Training Report Stanford, Provider Training Report Sutter PAMF, Provider Training Report - UCSF). **The corrective action plan for finding 5.3.2 is accepted.**