DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

August 20, 2024

Nina Maruyama, Chief Officer, Compliance and Regulatory Affairs *Via E-mail*
San Francisco Health Plan
50 Beale St.,12th Floor.
San Francisco, CA 94105

RE: Department of Health Care Services Medical Audit

Dear Ms. Maruyama:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of San Francisco Health Plan, a Managed Care Plan (MCP), from March 6, 2023 through March 17, 2023. The audit covered the period from March 1, 2022, through February 28, 2022.

The items were evaluated and 1 of 17 findings was a repeat finding on the subsequent 2024 Medical Audit; therefore, DHCS will assess remediation for the repeat finding in the 2024 Corrective Action Plan (CAP). As such, DHCS accepts and will provisionally close the 2023 CAP with finding 1.3.2 still needing remediation. The open finding is transferred to the 2024 CAP which has the same finding. The enclosed documents will serve as DHCS' final response to the MCP's 2023 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: Stacy Nguyen, Chief *Via E-mail*
Managed Care Monitoring Branch
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

Grace McGeough, Chief *Via E-mail*
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Joshua Hunter, Lead Analyst *Via E-mail*
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Jessica Delgado, Unit Chief *Via E-mail*
Managed Care Contract Oversight Branch
DHCS – Managed Care Operations Division (MCOD)

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

ATTACHMENT A
Corrective Action Plan Response Form

Plan: San Francisco Health Plan
Audit Type: Medical Audit

Review Period: 3/1/22 – 2/28/23
On-site Review: 3/6/23 – 3/17/23

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 Notice of Action "Your Rights" Attachment The Plan did not send updated NOA "Your Rights" Attachments to members for adverse benefit determinations in accordance with APL 21-011.	1. SFHP replaced the outdated NOA "Your Rights" Attachments on 3/13/2023, during the DHCS Medical Review Audit. SFHP provided DHCS with a Compliance Statement and verification of the Helpdesk ticket as additional evidence. 2. SFHP has implemented enhanced auditing and monitoring activities to help identify these deficiencies if they were to occur in the future. These activities include modification of the current audit/monitoring tools to review the version of the NOA attachments. 3. SFHP has also communicated this deficiency, the root cause, and action plans in various meetings, including the June Utilization Management Committee (UMC). 4. SFHP is working to implement	1. Compliance Statement and Helpdesk Ticket 2. Updated Audit Tool - Screenshot of updated version attached. Includes version control #/marketing print job #. The current "Your Rights" attachment has document ID #: "369401A" 3. June UMC Minutes – Discussed all UM and Quality Review team findings and CAP plans. Minutes and DHCS Finding & CAP Plan Grid	1. 3/13/2023- SFHP replaced the outdated NOA "Your Rights" Attachments & Provided Compliance Statement. **Implemented** 2. 4/25/2023- SFHP is now tracking all NOA attachment modifications. This process includes a quality review and sign off by the Clinical Operations Manager. **Implemented** 2. 4/20/2023- Audit/Monitoring Tool updates: Tools now incorporate attachment version verification into	The following documentation supports the MCP's efforts to correct this finding: **PROCEDURES** • Compliance Statement and Helpdesk ticket demonstrate the MCP identified a version control issue and replaced the outdated NOA "Your Rights" attachment. (1.2.1 Helpdesk TDX Ticket, 1.2.1 Compliance Statement) **MONITORING AND OVERSIGHT** • Screenshot of updated audit tool includes version control # / marketing print job # to verify correct version on template is used and prevent similar deficiencies. (1.2.1 Clinical Ops Response_Not for submission) • 6/21/23 UMCP minutes demonstrate audit findings and root causes discussed with UM staff. (1.2.1 June 2023 UMC Minutes UMC) **The corrective action plan for finding 1.2.1 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	better document version control procedures for forms and templates to help prevent these types of issues in the future. This includes a centralized forms management process and reference guide.		Internal Audit procedure. **Implemented** 3. June 2023- UMC notified of audit findings and CAP plans **Implemented**	
1.3.1 Notice of ppeal Resolution our Rights" ttachment he Plan did not send pdated NAR "Your ights" Attachments o members for pheld appeal ecisions in ccordance with APL -011.	1. SFHP has obtained the latest version of the NAR "Your Rights" attachment from DHCS and confirmed that this new version is in use as of 8/2/2023. The team responsible for sending out these forms were notified about the updated NAR attachment and to start using this updated form moving forward. 2. SFHP has identified an opportunity to update its current audit tools to include a check of document ID #'s to ensure that the most current versions are being used.	1. E-mail dated 8/1/2023 - Grievance & ppeals (G&A) upervisor notified e G&A team members sponsible for cessing appeals egarding the use f the updated NAR "Your Rights" attachment in peal letters that require the NAR	1. 8/2/2023 - Updated NAR "Your Rights". **Implemented** 1. 8/14/2023 updated translated NAR your rights in use. **Implemented** 2. 2/2024- Updating audit tools to include a check of document ID's. **Long-Term**	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Draft Policy XX-01 Forms, Notices and Templates Management was developed to manage the MCP's forms, notices and templates. The policy establishes a central repository that will be utilized as a central source of reference to catalog all existing forms, notices, and templates. (1.3.1 Forms, Notices, and Templates Management Policy – DRAFT_01042024)

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	3. SFHP is working to implement better document version control procedures for forms and templates to help prevent these types of issues in the future. This includes a centralized forms management process and reference guide.	"Your Rights Document". 1. Email dated 8/14/23- The G&A team members were informed of the updated translated versions of the NAR "Your Rights" attachment. 1. Updated NAR packet	3. 2/2024- Ongoing- Document Version Control Process. **Long-Term**	**IMPLEMENTATION** • Updated NAR "Your Rights" Attachment and translated "Your Rights" and emails dated 8/1/23 and 8/14/23 demonstrate the MCP is now using the correct NAR "Your Rights" attachment in both English and threshold languages. (1.3.1 NAR english usage email, 1.3.1 NAR Packet, 1.3.1 Updated NAR translation email usage 8-16) **MONITORING** • Appeal Audit Tool Template was updated to verify that the current forms are being used. (1.3.1 Copy of 2023_Appeals Audit Tool_Q2 2023) **The corrective action for finding 1.3.1 is accepted**.
1.3.2 Written onsent for Appeals The Plan did not sure that members' itten consent was received prior to	1. SFHP submitted QI-17 and the Member Consent Form to the Department of Managed Health Care (DMHC) for review and approval on 1/9/2023. On 8/4/2023, the Plan contacted DMHC regarding if it would be	1. DMHC portal submission and ommunication egarding review d approval of QI - d the Member onsent Form.	1. TBD- Use of Consent form Once approved by DMHC. **Long-Term** 2. 1/23/2023- DHCS provided approval to SFHP on P&P and	Finding 1.3.2 is a repeat finding from the 2024 Medical audit; it will be addressed through the 2024 DHCS CAP.

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closing cases when providers filed appeals on behalf of members.	possible to use the Member Consent Form. DMHC responded on 8/4/2023 and stated the Plan's filing remains under review. DMHC reviewed the policies and consent form and provided comments to SFHP on 8/10/23. The Plan has 30 calendar dates (9/10/23) to make the updates and resubmit to DMHC for approval. SFHP will resubmit the revised policies and form to DHCS once approved by DMHC. 2. SFHP submitted QI-17 and the Member Consent Form to DHCS for review and approval. SFHP received DHCS approval on 1/23/2023.	2. DHCS email communication regarding review and approval of QI-17 and the Member Consent Form.	Consent form. **Implemented**	
1.4.1 Medical Director Changes The Plan did not eport to DHCS all hanges in the status of the Medical	1. SFHP developed a policy and procedure for the submission of changes in key personnel, including changes in the Medical Director's status. The policy states the Plan is required to submit changes within ten calendar days.	1. Policy and Procedure - Reporting Key ersonnel Changes	1. This policy is already implemented. **Implemented**	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • P&P, CRA-33, "Compliance and Regulatory Affairs" (09/23) demonstrates the Plan has a process to notify

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Director within ten calendar days.				DHCS of changes in Medical Director's status within ten calendar days. (1.4.1 CRA-33 Key Staff Changes P_P) **MONITORING** • Desktop Procedures, "Monitoring Compliance with Personnel Changes" (effective 01/01/2024) demonstrates the Plan will have a process in place to monitor each month if there are any changes to Medical Director's status and to report to DHCS within 10 calendar days. (1.4.1 Monitoring Compliance with Personnel Changes DTP) • SFHP Policy and Compliance Committee Minutes, (01/18/24) demonstrates the Plan will make changes to the executive level personnel on a monthly basis. These updates are a standing agenda item on SFHP's monthly Policy and Compliance Committee (PCC). (1.4.1 January 2024 PCC Minutes) • Memo, "Monitoring Event-Personnel Changes" (01/18/24) demonstrates the Plan created a monthly memo addressed to their Policy and Compliance Committee regarding whether or not any executive-level personnel changes were submitted to DHCS Contract Manager

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				within 10 calendar days. **TRAINING** • Drafted Desktop Procedures was shared with appropriate staff on 10/01/23. **The corrective action plan for finding 1.4.1 is accepted.**
1.5.1 Criteria and Explicit Clinical Reason in Notice of Action The Plan did not ensure the delegate included reference to the specific criteria and guideline used to support the decision and the clinical reason for the decision, including explicit reason why the	1. As a result of the finding, Delegate is currently under quarterly file review which includes review of NOA letters. SFHP intends to include audit results in CAP response to demonstrate that Delegate is adding clinical reason/criteria to their NOA letters. 2. It is SFHP's process to add delegates to quarterly reviews if they fail any "must pass" elements. Delegates are removed from quarterly reviews after successfully passing 2 quarters. SFHP has proactively implemented a quarterly file review for all Delegates. This includes	1. Delegate quarterly review notification. 2. CRA Desktop Procedure - Delegate Oversight (Page 2- Highlighted) 2. Audit Schedule - Quarterly File Review	1. June 2023- Quarterly Reviews Implemented Implemented	The following documentation supports the MCP's efforts to correct this finding: **MONITORING** • Delegate quarterly review notification email dated 8/8/23 notifies delegate that as a result of this finding, the delegate will be placed under quarterly review until delegate demonstrates two successful quarter of full compliance before returning to annual audit schedule. (1.5.1 NEMS DHCS CAP Notification) • Audit schedule demonstrates the MCP has moved all its delegates to quarterly file review as a result of this finding. (1.5.1 Audit Schedule 2023)

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member's condition did not meet criteria, in NOA letters for adverse benefit determinations based on medical necessity.	approved and denied UM authorization request files and NOA.			• Q1 and Q2 2023 File Review Audits demonstrates there is a process in place to monitor the presence of specific criteria and guidelines used to support the decision. The audits contain requirements for corrective action from the delegate. (1.5.1. Doc 1 & 1.5.1 Doc 2) • Delegate UM Workgroup Agenda (8/24/23) and Email to Delegate (8/25/23) demonstrate the MCP introduced a new format to the UM ALL ACTIVTY REPORT. The new report differentiates between denial type SME can accurately pull and review medical necessity denials. (1.5.1 Doc 3 & 1.5.1 Doc 4) • UM All Activity Report is focused on UM specific information enabling the MCP's SME to accurately pull and review medical necessity denials, confirming the file review universe contains enough medical necessity denials. (1.5.1 Updated All_UM_ Activity_Report_Template_82023) **The corrective action plan for finding 1.5.1 is accepted.**
1.5.2 Ownership and Control Disclosure	1. SFHP revised the ownership and disclosure form and had it vetted by DHCS to ensure all required	1. Revised Ownership and Disclosure Form	4. 4/27/2023- Completed disclosure forms received from	**TECHNICAL ASSISTANCE** Plan is no longer required to submit any ownership and

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Review The Plan did not collect and review ownership and control disclosure information for their UM delegates.	information was requested. DHCS approved this revised form in October 2022. 2. SFHP implemented in December 2022 a Credentialing Desktop Procedure (DTP) to monitor and oversee the process of collecting the ownership and disclosure form. During the March 2023 audit, DHCS explained they were validating the information against the California Secretary of State BizFile Online database. This enabled the SFHP to review the form for completeness. 3. SFHP sent revised disclosure forms to delegates on 1/13/2023. 4. SFHP received completed disclosure forms from its UM delegates. 4/27/2023. 6. One Delegate is past due to submit an updated disclosure form as part of	2. Credentialing DTP (Page 2- highlighted) 4. Screenshot of received disclosure forms in SharePoint library 6. Email to Delegate requesting updated disclosure form.	Delegates. Implemented.	disclosure information containing Personally Identifiable Information (PII) to DHCS as part of the Corrective Action Plan (CAP). The Plan must continue to demonstrate 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 guidance refer to 4/23/24 DHCS MACC e-mail.) **The corrective action for finding 1.5.2 is accepted**

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	the 3-year cycle review process. An updated form has been requested.			
1.5.3 Qualified Medical Personnel The Plan did not ensure that its UM delegate's medical decisions were rendered by qualified medical personnel.	1. Delegate has been informed that even approvals require a clinician. 2. SFHP will require Delegate to provide an updated P&P/attestation that ALL authorization requests that require a medical necessity assessment will be reviewed by a licensed clinician. 3. SFHP has added Authorization "Approvals" to the annual and quarterly audits to confirm this change has been implemented.	1. Email sent to Delegate on 08/03/2023 outlining the Medical Audit findings. Delegate was asked to provide a CAP response to this finding. 2. Delegate P&P revision	1. 8/3/2023- SFHP informed Delegate (NEMS) about this finding and requested a CAP. **Implemented** 2. 8/8/2023- Delegate provided updated P&P **Implemented**	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Revised P&P, DO-02, "Oversight of Delegates", (09/20/23) revised to include that once the pre-delegation audit has been completed, SFHP will communicate its findings in writing to the prospective Delegate. If deficiencies are identified, a corrective action plan (CAP) is requested. When the CAP is submitted, the SFHP audit team will evaluate the response and approve or request additional information as necessary. (1.5.3 DO-02_Oversight_of_Delegated_Functions) • Preliminary audit results will be communicated to the Delegate within 60 days from the completion of the audit. If deficiencies are identified, a corrective action plan (CAP) is requested. When a CAP is submitted by Delegate, the SFHP audit team will evaluate the response and issue either an approval or a request for additional information. Delegates' corrective actions are tracked by PNO as outlined in P&P PR-20.

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				• P&P, PR-20, "Enact Corrective Action Plans" (07/22/21) demonstrates how the Plan enacts delegation oversight with corrective action plans. (1.5.3 PR-20 Enact Corrective Action Plans_2021.07.22) • Revised, SFHP Desktop Procedure, "Oversight of Delegated UM Functions", (12/11/23) revised to include procedures for UM approvals file audit (file review). **MONITORING AND OVERSIGHT** • Quarterly Audit, Q2 audit of NEMS/NMS, (04/01/23 – 06/31/23) demonstrates the deficiencies from this audit were corrected. In addition, these deficiencies were shared and promptly acknowledged by NEMS. • 2023 NEMS Annual Audit, (01/01/23 – 12/31/23) out of 30 UM files reviewed, 77% were compliant with the requirement of having it's UM delegate's medical decisions rendered by qualified medical personnel. **IMPLEMENTATION** • Updating audit tool and DTP to include review of

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				approved files. (Both of these document updates will require approval at UMC.) • Copy of the DMG UM Workgroup Agenda on 8/24/2023 where DMGs were advised that all groups will be subject to routine quarterly audits that will include approval files starting Q2. • SFHP has begun monitoring approval files in addition to denial files and verifies the NEMS staff responsible for applying criteria and decision making are licensed clinician's. **TRAINING** • E-mail sent to Delegate on 08/03/2023 outlining the Medical Audit findings. **The corrective action plan for finding 1.5.3 is accepted.**
1.5.4 Consistent Application of Criteria	1. Delegate will be asked to provide most recent Inter-rater Reliability (IRR) results.	1. Email Communication to Delegate outlining audit findings and	1. 8/2023- Delegate notified of findings by SFHP and requested CAP. SFHP also	The following documentation supports the MCP's efforts to correct this finding.:

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The Plan did not ensure that the delegate's written criteria and guidelines used for utilization review were consistently applied.	2. SFHP has changed its audit practice to include IRR review in every annual audit.	requesting CAP response.	requested IRR results. **Implemented**	**POLICIES AND PROCEDURES** • Delegates UMP described its annual IRR. The delegate evaluates annually the consistency with which the physicians and non-physician reviewers (UM Nurse and UMCs) involved in utilization review apply the criteria used in decision-making. (1.5.4.4 Page 27) **MONIOTRING AND OVERSIGHT** • Email notification from 8/8/23 demonstrates the MCP has notified the delegate that monitoring of IRR will be included in the annual audit going forward. (1.5.4 NEMS email). The MCP also required the delegate to submit its most recent IRR results as a part of its CAP response. (NEMS DHCS CAP Items 08/08/23) • Updated Audit Tools for Delegates for both full and limited scope audits now include annual review of IRR report and policy. (1.5.4 Doc 2 & 1.5.4 Doc 3) **The corrective action plan for finding 1.5.4 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 Health Information Form/Member Evaluation Tool Documentation The Plan did not ensure that HIF/METs were mailed to newly enrolled members.	1. SFHP has updated its report to include all members with a "New Enroll" action in the system (QNXT). After this change, all qualified new Medi-Cal Members under age 3 will be included on the HIF/MET mailing list. According to the report logic, a New Member is one who has a New Enroll action in QNXT and did not have any MC enrollment in the last 3 months. For example, if a member had a new enrollment on 8/1, the report checks to see if the member was active in May 2023, June 2023, or July 2023. If they were, they would be excluded from receipt of HIF/MET. But if their last enrollment ended 4/30/2023 (or prior), then they would show up on the report.	1. Evidence of the report methodology change	1. 2/23/2023- SFHP has updated and implemented its report to include all members with a "New Enroll" action in the system (QNXT) Implemented 1. 2/16/2023- Report methodology/logic was revised. Implemented	The following documentation supports the MCP's efforts to correct this finding: **POLICY AND PROCEDURES** • "New Member Welcome Packets with HIF/MET Form – SSRS Report Specification" (02/16/23) as evidence that the MCP has updated and implemented its report to include all members with a "New Enroll" action in the QNXT system. (Highlighted New Member HIF MET Mailing Report Specs). • "Service Ticket" (09/07/23) as evidence that the MCP has submitted a Report Request to update the report '0527Q HIF/MET Mailing List' to no longer exclude members aged 0-35 months. (2.1.1 CAP Ticket). • Updated P&P, "CARE-02: Health Information Forms and health Risk Assessments" (09/21/23) which states that the MCP will mail a DHCS approved Health Information Form (HIF)/Member Evaluation Tool (MET) to all newly enrolled members as a part of SFHP's Welcome Packet and include a postage paid envelope for response. Each new member receives their own HIF/MET assessment. (CARE-02 Health Information Forms and Health Risk Assessments, Page 1).

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				MONITORING AND OVERSIGHT • "Health Information Form-Member Evaluation Tool Audit" (03/18/24) and "HRA HIF-MET Audit Checklist" (Quarter 4, 2023) as evidence that the MCP conducted an internal audit to demonstrate that HIF/METs were mailed to newly enrolled members. The audit report is to be distributed to the Customer Service and Marketing departments for review and corrective action. A Corrective Action Plan (CAP) will be required to be submitted to the Compliance and Oversight Department within 30 days of presentation. (HIFMET Preliminary Report, Q4 Fiscal Year 2023 HIF MET Audit Tool). • "HRA HIF/MET Corrective Action Plan (CAP) Form Internal CAP" (Quarter 1, 2024) as evidence that the MCP conducted an internal audit to demonstrate that HIF/METs were mailed to newly enrolled members. The MCP has updated its report to include all members with a "New Enroll" action in the system (QNXT). After this change, all qualified new Medi-Cal Members under age 3 will be included on the HIF/MET mailing list. (HRA CAP 2023). **The corrective action plan for finding 2.1.1 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
2.1.2 Provision of Initial Health Assessment The Plan did not ensure the provision of a complete IHA to each new member.	1. Hired new Population Health Manager to oversee IHA, 8/8/2023 2. A multi-disciplinary workgroup focused on IHA's was created on June 2023. This group is responsible for identifying strategies to help remediate any IHA gaps, and processes to help increase the provision of complete IHA's to new members. Part of this strategy is to create visibility and routine reporting on IHA's through the use of data analytics and flagging. 3. SFHP is working to update the IHA reporting coding for complaint visits. This new report will be added and sharing securely with clinics to inform them of new members that do not have an IHA visit. PHM Director updated request for IHA deficiency Report ticket through internal SFHP	2. June, July, August Minutes from the IHA-Preventive Services Workgroup. 4. Program Integrity Workplan (Page 8; highlighted)	1. 8/08/2023- Population Health Manager Hired **Implemented** 2. 6/14/2023- New workgroup headed by Compliance started in June 2023. **Implemented** 3. 9/29/2023- New IHA report to be shared with clinics **Short-Term**	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Plan revised Policy HE-02 Initial Health Appointment to comply with updated APL 23-030 and Population Health Management Policy Guide. Policy indicates that the Plan will hold providers accountable for providing all preventive screenings for adults and children. Addresses completion timeframes, outlines potential exceptions, EPSDT requirements. **MONITORING AND OVERSIGHT** • Plan has established a member incentive program which includes information on the importance of completing an IHA, what will happen during a member's exam/visit and the necessary contact numbers. If a member schedules/completes an IHA within 120 days of enrollment, they will be entered into a raffle for a chance to win a gift card. • Plan developed and implemented an IHA Rate Report that is used for three primary functions:

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	process. Targeted completion date 9/29/23. 4. Program Integrity Workplan Updated to reflect increased IHA oversight.			1. To inform SFHP of the IHA completion rate to drive educational opportunities. 2. To provide SFHP Delegated Medical Groups responsible for primary care their IHA completion rates. 3. To provide a monthly report to Primary Care Clinics of their newly enrolled members that are eligible for an IHA. Plan implemented a Chart Audit. The scope of the audit includes: • 10 medical histories were requested from 5 medical groups responsible for Primary Care. Delegation Oversight is auditing to validate that Preventative Services were provided according to the USPTF A & B periodicity schedule and that the IHA was conducted timely. • Plan submitted IHA Audit Report (2/15/24) which is made up of a random sampling from each medical group. o Objectives included: Completion of IHA within 120 days, fulfillment of IHA requirements, compliance with regulatory /contractual requirements (documented and performed). o Findings included failing to meet completion timeframe and record documentation of required components. o Per the Plan, the initial audit was utilized as a benchmark to determine if the methodology is capturing IHAs appropriately and provide insight to the workgroup to guide next steps. The

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				IHA report will be presented to the IHA and Preventive Services workgroup to determine appropriate remediation. A CAP will be required to be submitted to the Compliance and Oversight Department. o Full implementation is expected to begin July 2024. Note: The 2023 CAP focused on establishing procedures and processes. The 2024 medical audit will focus on overall implementation and efforts to address non-compliance. **The corrective action plan for finding 2.1.2 is accepted.**

3. Access and Availability of Care

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
3.8.1 Physician Certification Statement Form – Required Information The Plan did not collect all required information on PCS forms for NEMT requests.	1. Retrained intake staff on PCS form requirements April 2023. 2. Developed PCS form requirement checklist template for staff in May 2023. 3. Hired full time Transportation Coordinator 5/16/2023 to specialize in NEMT authorizations and work directly with referring providers to ensure PCS form accuracy. 4. Added Transportation focused audit to internal audit procedure Q2 2023. 5. Informed Utilization Management Committee of Audit findings & CAP plans 6. NEMT assessment updated and embedded into each NEMT authorization in July 2023.	1. Agenda/Training Log 2. PCS Form requirement Checklist 4. Transportation Audit Schedule 5. June UMC Minutes – Discussed all UM and Quality Review team findings and CAP plans. Minutes and DHCS Finding & CAP Plan Grid 6. Updated NEMT Assessment	1. April 2023- Retrained Staff **Implemented** 2. May 2023- Developed PCS checklist **Implemented** 3. 5/16/2023 - Hired full-time Transportation Coordinator **Implemented** 5. June 2023- UMC notified of findings and CAP plan **Implemented** 6. July 2023- NEMT assessment updated	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Revisions to Plan policy "CO-28_Transportation_PCS Form Requirements" demonstrates the Plan verifies the completeness of all PCS forms. If incomplete or incorrect, the form will be returned to the prescribing provider to obtain the missing information & resubmit. The request is considered incomplete & will not be process until a correctly completed form is received. (Intake Process – PCS Verification, 1. b. ii., page 2) **MONITORING AND OVERSIGHT** • Internal Tracker, "NEMT Audit Tool" demonstrates the tracker utilized to perform the quarterly Internal Audits. • Internal audit report, "Q4-2022 Internal Audit Results" demonstrates the Plan's monitoring & oversight process, auditing the completion of PCS forms on a quarterly basis.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
			Implemented	**TRAINING** • "NEMT Process Update" demonstrates the Plan gave notice to all providers of the revisions made to its DTP "CO-28: Transportation", highlighting that the Plan will no longer be accepting incomplete/missing PCS forms & that providers will be contacted to re-submit & that the request will not be processed until a correctly completed form is received. • "Provider Education Emails" demonstrate the Plan's corrective action process of not accepting incomplete/missing PCS forms & reaching out to the provider to re-submit a correctly completed form. (See Provider Education Emails 1-3) **The corrective action plan for finding 3.8.1 is accepted.**
3.8.2 Provision of Non-Medical Transportation Services The Plan did not provide urgent NMT services necessary for	1. SFHP completed an RFP process to secure a transportation broker that can manage and fulfill same day and urgent rides, along with regularly scheduled rides. This will apply for both NMT & NEMT. Currently in the contracting phase with transportation broker. (On Track)	1. The transportation contract is not yet ready, but attached are the RFP responses from broker, and some of the follow up documentation	1. 1/1/2024-Projected go live for services with transportation broker. **Long-Term** 2. 3/1/2023-Interim solution in	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Plan policy "CS-12 Non-Medical Transportation Requests" demonstrates the process of the member being able to pick up the NMT assets from the Plan's service center for urgent NMT requests in order for members to obtain medically necessary

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
members to obtain medically necessary Medi-Cal services, including those not covered under the Contract.	2. In the interim, currently we do offer same day pick up of NMT assets at the SFHP Service Center and have worked with a Taxi vendor to schedule same day rides, which has been very successful. We are working to implement our vendor ASAP.	they provided. RFP: Highlighted in green relevant sections on pages 10, 12, 27 & 29. 2. CS-12 Non-Medical Transportation	place **Implemented**	Medi-Cal services. (Procedure, 3., page 2) • Plan procedure "Mgmt Processg_NMT Requests_DTP" demonstrates the process for urgent NMT requests where members are able to pick up the NMT assets from the Plan's service center & the Plan is also able to arrange transport directly with Flywheel. (Exceptions, page 2 & 3) **MONITORING AND OVERSIGHT** • Plan procedure "Mgmt Processg_NMT Requests_DTP" demonstrates that on a monthly basis, the Customer Service Manager or designee reviews all NMT requests received within the calendar month to verify any urgent and/or same-day requests were completed appropriately. (Monitoring, page 3) • Plan tracker "NMT Auditing Log" demonstrates the Plan's monthly process where all NMT requests received within the calendar month are pulled/reviewed, verifying any urgent and/or same-day requests were completed appropriately. (See NMT Auditing Log) **The corrective action plan for finding 3.8.2 is accepted.**
3.8.3 Monitoring Activities for NEMT and NMT services	1. Monthly Transportation Workgroup implemented in April 2023. Workgroup objectives include:	1. Workgroup Minutes (April-Aug 2023)	1. April 2023-Transportation Workgroup	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 conduct monitoring activities at least quarterly for transportation services.	- Monitor Member Experience / Satisfaction - Monitor Utilization and Cost
	- Monitor Fraud, Waste, and Abuse
	-Identify opportunities for Member and Provider Education
	
	2. Transportation Broker Implementation go-live 1/01/2024- Transportation broker has enhanced reporting capabilities allowing SFHP to capture more comprehensive data to support transportation monitoring activities. For example, GPS tracking of drop off & pick up locations and times, member satisfaction, etc.
	
	3. Informed Utilization Management Committee of Audit findings & CAP plans
	
	4. 2 NEMT audits added to the Internal Audit workplan for FY 23-24
		2. Documentation for Transportation Vender RFP (Attached)
		
		3. June UMC Minutes – Discussed all UM and Quality Review team findings and CAP plans. Minutes and DHCS Finding & CAP Plan Grid
		
		4. Internal Audit Workplan - 2 NEMT audits added for FY 23-24 (Page 8; highlighted)
			Implemented **Implemented**
			
			2. 01/01/2024- Projected go-live for services with transportation broker. **Long-Term**
			
			3. June 2023- UMC Informed of findings and CAP plans **Implemented**
			
			4. 10/2023- Internal Audit Workplan - 2 NEMT audits added for FY 23-24 **Implemented**
				POLICIES AND PROCEDURES
				
				• Plan policy "CO-28_Transportation" demonstrates the Plan now utilizes its transportation workgroup to monitor & oversee the NMT & NEMT benefits. (MONITORING, 1-8, pages 7 & 8)
				
				MONITORING AND OVERSIGHT
				
				• Plan policy "CO-28_Transportation" demonstrates the Plan's transportation workgroup monitors monthly for member experience/satisfaction, utilization & cost, compliance with regulatory standards, & also identifies opportunities for continued member & provider education. Reports of the Plan's monitoring activities are provided to the QIC for evaluation & corrective actions as needed. (MONITORING, 1. & 7., page 7 & 8)
				
				• Q1_NEMT_Audit_Tool
				  ○ The audit tool demonstrates the Plan's quarterly audit tool used to monitor transportation activities. SFHP's Clinical Operations Team follows the 8/30 audit methodology. For the 8 randomly selected files, there were no non-compliance findings.
				
				• Transportation Wkgrp_6.20.2023
				  ○ The Plan demonstrates it discussed all UM & Quality

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

				Review team findings, plus CAP plans. (Page 3-4)
				
				• Transportation Wkgrp_8.11.2023
				  ○ The Plan provided workgroup meeting notes from its monthly transportation workgroup meeting that demonstrates transportation related data being reviewed for any trends & addressed. (Page 7- 8)
				  ○ The Plan demonstrated it conducts monitoring activities at least quarterly for transportation services.
				
				The corrective action plan for finding 3.8.3 is accepted.

3.8.4 Transportation Wait Times The Plan did not inform members that they must arrive within 15 minutes of their scheduled NEMT or NMT appointment.	1. Transportation Broker Implementation – In Request for Proposal (RFP) phase, Transportation Broker stated that Members will be informed of the 15-minute requirement. 2. Verbiage added to NEMT Approval Notices – implemented 7/19/2023 3. Customer Service will implement a call script for intake of NMT requests upon implementation of the new	1. The transportation broker contract is not yet ready, but attached are the RFP responses from the transportation broker, and some of the follow-up documentation they provided. RFP: Highlighted in	1. 01/01/2024- Projected go live for services with transportation broker. **Long-Term** 2. 7/19/2023- Verbiage added to NEMT Approval Notices – implemented **Implemented**	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Verbiage_NEMT Approval Notices demonstrates the following verbiage was added & translated into all threshold languages stating "Please Note: Transportation providers are required to provide door to door service and drop you off 15 minutes ahead of your scheduled appointment. If this does not occur, please call SFHP's Customer Service Department at 1(800) 288-5555 and report your experience." NEMT Assessment is embedded into each NEMT authorization demonstrating consistent application.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	transportation broker. Monitoring of the pick-up and drop off times will be available when members take transport that is outside of public (subway, bus) 4. EOC Update - Work begins on this in Fall, 2023. Should have an updated, final 2024 EOC either in January or February 2024. 5. In the interim, SFHP has also updated the Customer Service (CS) Desktop Procedure (DTP) for intake/ completion of NMT requests and added verbiage about arrival times (attached). This will also undergo another update once our vendor is implemented due to expected changes in the intake process pending their (Transportation Broker) scheduling system. 6. Informed Utilization Management Committee of Audit findings & CAP	green relevant sections on pages 10, 12, 27 & 29. 2. Verbiage added to NEMT Approval Notices. NEMT Assessment is embedded into each NEMT authorization ensuring consistent application. Verbiage translated into all threshold languages. 5. New Customer Service Desktop Procedure update for intake of NMT requests	3. 9/29/23- NMT/NEMT script development & implementation in process. Note: Waiting on this because we want the script to reflects the process for intake with the new transportation broker. **Short-Term** 4. January or February, 2024- EOC Update - Work begins on this in Fall, 2023. **Long-Term** 5. 8/4/2023 - Customer Service	**MONITORING AND OVERSIGHT** • The meeting minutes, "Transportation Workgroup_6.20.2023" demonstrate the notes from the Plan's implemented workgroup where it discussed all NMT/NEMT findings & CAP plans. • DTP Processing NMT Requests demonstrates that part of the NMT request process is to advise that the member must arrive within 15 minutes of their scheduled appointment time. • ModivCare Solutions_RFP_NMT_NEMT demonstrates the Plan's long-term goal to obtain a transportation vendor of which would help with the Plan's deficiencies identified. The RFP outlines the vendor's role & responsibility around the transportation services – door to door services – being a part of that. (Pages 10, 12, 27 & 29) **The corrective action plan for finding 3.8.4 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	plans 7. Monthly Transportation Workgroup implemented in April 2023. Workgroup objectives include: - Monitor Member Experience / Satisfaction -Monitor Utilization and Cost -Monitor Fraud, Waste, and Abuse -Identify opportunities for Member and Provider Education	6. June UMC Minutes – Discussed all UM and Quality Review team findings and CAP plans. Minutes and DHCS Finding & CAP Plan Grid 7. June Transportation Workgroup Meeting Minutes – Discussed all NMT/NEMT findings and CAP plans.	Desktop Procedure (DTP) for intake/ completion of NMT requests. **Implemented** 6. June 2023- Informed UMC of Audit Findings and CAP plans **Implemented** 7. April 2023- Transportation Workgroup Implemented. **Implemented**	

5. Quality Management

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
5.1.1 Evaluation of Potential Quality Issues The Plan did not evaluate PQIs to determine if actions to address quality of care issues were necessary.	1. Staffing updates- Added 2 Quality Review (QR) Nurse positions in Nov. 2022 with a 3rd to start on 8/12/2023. Additionally have approval to hire a QR Navigator who will support Quality Review Registered Nurses. Job will be posted by 9/1/23, the primary focus of the role will be to assist members directly in obtaining care and equipment they need in a timely way and will provide admin support in the processing of PQI. 2. Revised PQI log Jan 2023 that is used for tracking turn-around times until new care management software is implemented in 2024. 3. New Care Management System. The system is anticipated to go live Feb 2024. The System will provide an electronic method of tracking, progress of cases, clear assignment of activities related to PQI to specific	2. Blank copy of updated PQI Log 4. Current QI-18 Policy	1. Aug/Sept 2023- Have hired one QRRN, anticipate hiring second QRRN and QR Navigator. **Implemented & Short-Term** 2. 1/2023- Updated PQI Log **Implemented** 3. 2/2024- New Care Management System Implementation. **Long-Term** 4. 1/23/2023- Policy QI- 18 updated **Implemented** 5. Nov 2023- QI-18 in revision. Needs PAC approval in Oct,	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Revised Policy, "QI-18: Potential Quality Issues" (01/25/2023) states that LVNs will refer PQIs to either the RN for clinical assessment or MD for final determination. "The QRN completes the initial review and if the QRN (RN) determines that there is no PQI (rating of P0/S0), the rating will be entered in the case management system and the case closed. When the QRN (LVN) reviews the available information, case will be referred to either QRN (RN) for clinical assessment or Medical Director for final decision. If the QRN (RN/LVN) identifies a potential quality issue or cannot determine whether there is a quality issue, the QRN forwards to the Medical Director for secondary review and determination." (5.1.1 QI-18 PQI_2023.01.25, Section C (3)) • The policy further outlines the PQI process which is designed to address provider clinical decision making and behaviors that may present potential or real harm to members. **MONITORING AND OVERSIGHT**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	individuals, improve reporting capabilities which will improve our auditing capabilities. 4. Policy QI-18 revised effective 01/23/2023 which extended PQI turn-around time to 180 days. 5. Policy QI-18 developed Jan 23, 2023, but there are changes pending approval by the Physician Advisory Committee (PAC) that should be reviewed at the next PAC in October 2023. It will then be presented at SFHP's Policy & Compliance Committee (PCC) for final approval. The pending changes to QI-18 are intended to improve timely processing of PQIs.		then approval at Policy & Compliance Committee Meeting (PCC) projected in November. **Long-Term**	• P&P, "QI_18: PQI" and DTP, "Confirmed Quality Issues Corrective Action Plan" outline procedures for quality issue corrective action plans. QI Department will collaborate with Plan Medical Directors to assess necessity for corrective action. Providers/facilities are required to execute CAPs within 30 calendar days. Plan will conduct implementation reviews to verify corrective actions have been put into practice and all deficiencies have been rectified. (5.1.1 QI-18 PQI_2023.01.25, Section F (2) (b, c, d) and 5.1.2 Confirmed Quality Issue Corrective Action Plan DTP-Draft) • Plan has hired additional staff Quality Review Registered Nurses (QRRN) and approved a QR Navigator position to address staffing issue. (Attachment B (08/18/23)) • A sample PQI log (Jan. 2023) demonstrates tracking of turn-around times, until new care management software is implemented in 2024. The Plan indicates TAT has been met since implementation – May 2023. (5.1.1- PQI Log Sample) **The corrective action plan for finding 5.1.1 is accepted.**
5.1.2 Effective Action for PQIs	1. QI-18 revised which clarifies role of Physician Advisory Committee in PQI determinations. Procedure changed in	1. Draft of updated Policy QI-18 with	1. November 2023-revised QI-18 in progress still needs	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 take effective action to address needed improvements for PQIs.	June 2023 which will be reflected in the updated QI-18. Changes are pending approval by the Physician Advisory Committee (PAC) that should be reviewed in October 2023 PAC meeting. It will then be presented at SFHP's Policy & Compliance Committee (PCC) for final approval. 2. Quality Review Registered Nurses (QRRNs) have begun sending a notification letter to provider of concern within 1 week. We instituted this in mid-June for those cases where we are unable to review the documentation and develop PQI questions within the 1-week timeframe. These new letters allow us to notify the provider in a timely way that a case has been opened. This is one of the additions to QI-18. Another change is that we have reverted to allowing the QRN to determine when there is no PQI rather than send all cases to the Medical	proposed changes 2. Blank notification letter template to Providers	PAC approval and presented to PCC **Long-Term** 2. June 2023- Implemented sending notification letters to provider of concern. **Implemented** 3. June 2024- Full implementation of corrective action plan DTP after necessary approvals. **Long-Term** 4. 9/1/2023- QR Navigator job description will be posted. **Short-Term**	**POLICIES AND PROCEDURES** • Revised Policy, "QI-18: Potential Quality Issues" (01/25/2023) states that LVNs will refer PQIs to either the RN for clinical assessment or MD for final determination. "The QRN completes the initial review and If the QRN (RN) determines that there is no PQI (rating of P0/S0), the rating will be entered in the case management system and the case closed. When the QRN (LVN) reviews the available information, case will be referred to either QRN (RN) for clinical assessment or Medical Director for final decision. If the QRN (RN/LVN) identifies a potential quality issue or cannot determine whether there is a quality issue, the QRN forwards to the Medical Director for secondary review and determination." (5.1.2 PP_CQ (QI-18 PQI) PAC Approved 12/18/23, Section C (3)) • P&P, "QI_18: PQI" and DTP, "Confirmed Quality Issues Corrective Action Plan" outline procedures for quality issue corrective action plans. QI Department will collaborate with Plan Medical Directors to assess necessity for corrective action. Providers/facilities are required to execute CAPs within 30 calendar days. Plan will conduct implementation reviews to verify corrective actions have been put into practice and all deficiencies have been rectified. (5.1.1 QI-18 PQI_2023.01.25, Section F (2) (b, c, d) and 5.1.2 Confirmed Quality Issue

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	Director. This practice is in line with other health plans and is expected to increase our compliance with our internal TATs. The validity of these decisions will be monitored through the IRR process. Additionally, we have specifically included SNF, LTC, Subacute, DD and ICF facilities to reflect the post-acute carve-ins implemented in Jan 2023 and anticipated for Jan 2024. QRRN is changed to QRN (Quality Review Nurse, to allow employment of qualified LVNs for these positions.) 3. Develop Corrective Action Plan DTP with templates. SFHP has begun sending corrective action plans as recommended by PAC since March 2023. QRRNS are developing a clear DTP for implementing corrective action plans including template language with expected presentation to PAC on 12/2023 and full implementation date of 6/30/2024.			Corrective Action Plan DTP-Draft) • Plan submitted revised duty statements for the following positions – Quality Review Nurse and Senior Quality Review Nurse. (5.1.2- Quality Review Nurse-2023; 5.1.2- Senior Quality Review Nurse-2022) **MONITORING AND OVERSIGHT** • Sample PQI Notification letter demonstrates providers are notified that a PQI investigation has been initiated. (5.1.2- PQI230327002 - QI Confirmation Letter_Redacted) • Sample PQI Notification Letter with Clinical Request is used to request written provider response and submit clinical documentation. (5.1.2- PQI230425001 - PB QI Confirmation Letter_Redacted) • The Plan demonstrated that the CAP process was implemented in March 2023. • Sample #1 (10/7/23) informed provider of medical director review and severity level assignment. No corrective action was required, but Plan will monitor.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	4. There has been approval to hire a QR Navigator who will support QRRNs. Job will be posted by 9/1/23. The primary focus of the role will be to assist members directly in obtaining care and equipment they need in a timely way and will provide admin support in the processing of PQI.			• Sample #2 (10/9/23) informed provider of medical director review and severity level assignment. Improvement at both the provider and system levels identified. Areas of concern were outlined, and provider response requested. **The corrective action plan for finding 5.1.2 is accepted.**
5.1.3 Audit of Plan's Records and Documents The Plan did not allow DHCS to inspect and audit all of the Plan's records and documents, and the Plan did not furnish requested records to DHCS that were needed to evaluate quality of services.	1. SFHP strongly disagrees with this finding. DHCS was allowed access to all records for review, and none were withheld. SFHP provided DHCS A&I auditors multiple opportunities to inspect and audit the records in question. We look forward to working with MACC to come to a resolution on this finding.	1. SFHP response to the Medical Audit preliminary finding on 5.1.3	1. Allow DHCS to inspect and audit SFHP's records. **Implemented**	The following documentation supports the MCP's efforts to correct this finding: For the review period of 3/1/22 – 2/28/23, DHCS requested electronic files of all meeting minutes, attachments, and packets for the PAC meetings. Although the MCP submitted PAC meeting minutes with limited information to DHCS, the MCP did not submit the associated packets. For future reference, pursuant to Welfare and Institutions Code section 14456 and the terms of the MCP contract, MCPs are required to furnish all documentation necessary to assist DHCS complete its audits. The terms of the MCP contract do not restrict the types of documentation that DHCS may request from the MCP. As such, the MCP must allow DHCS to audit, inspect, monitor, or

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				otherwise evaluate the quality, appropriateness, and timeliness of services performed under the Contract and to inspect, evaluate, and audit any and all premises, books, records, equipment, facilities, contracts, computers, or other electronic systems maintained by the MCP and subcontractors pertaining to these services at any time. Upon request, through the end of the records retention period, the MCP must furnish any record, or copy of it, to DHCS at the MCP's sole expense. (Contract A24, Exhibit E, Attachment 2 (20)). Plan was issued DHCS Guidance pertaining to the Inspection Rights provision of the MCP contract. **The corrective action for finding 5.1.3 is accepted.**

*Attachment A must be signed by the MCP's compliance officer and the executive officer(s) responsible for the area(s) subject to the CAP.

Submitted by: Nina Maruyama, MPH, CHC
Title: Chief Compliance and Regulatory Affairs Officer

Signed by: [Signature on File]
Date: 8/18/2023