CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

March 19, 2025

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

*Via E-mail*

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 31, 2023 through August 10, 2023. The audit covered the period from July 1, 2022, through June 30, 2023.

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

**Review Period:** 07/01/2022 - 06/30/2023

**Audit:** Medical Audit

**On-site Review:** 07/31/2023 – 08/10/2023

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 Letters to Members**<br>The Plan did not send NOA letters to members in denials of retrospective and concurrent authorization requests | HPSM policies UM.009 and UM.019 have been updated to include inpatient concurrent denials under its existing NOA Denial Letter workflow. This workflow includes all existing monitoring activities. Inpatient concurrent NOA letters are being sent to members effective Q2 2023. | » 1.2.1 UM.009 Retrospective Review of Authorizations 20240226<br>» 1.2.1 UM.019 Medi-Cal NOA Letter Template Process 20240226<br>» 1.2.1 Sample Case Files 20240226 | 8/30/2024 | The following documentation supports the MCP's efforts to correct this finding**:**<br>**POLICIES AND PROCEDURES**<br>» UM.009 Retrospective Review of Authorizations was updated by the MCP to include the sending of NOA letters in cases of retrospective reviews. (1.2.1 UM.009 Retrospective Review of Authorizations 20240226)<br>**MONITORING AND OVERSIGHT**<br>» Monthly UM IP NOA Letter Reports from 2/2024 demonstrate the MCP has incorporated the monitoring of inpatient concurrent and retro NOAs into their current monitoring procedure. (1.2.1 Monthly UM IP NOA Letter Report (Modified) 2024.02_20240510, 1.2.1 Monthly UM IP NOA Letter Report 2024.02_20240510)<br>» Sample Resolution letters demonstrate the MCP is sending denial letters for retrospective and concurrent denials for inpatient hospital stays. (1.2.1 Sample Case Files 20240226)<br>**The corrective action plan for finding 1.2.1 is accepted**. |
| **1.3.1 (Rpt. of 1.3.1 2022)** | The Plan updated policy GA.08 Appeals Policy as part of the 2022 DHCS Audit CAP response. No | » 1.3.1 GA.08 Appeals Policy 20240226 | 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 |
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| **Written Consent from Member for Appeals Filed by Provider**<br>The Plan did not ensure that members' written consent was received when providers filed appeals on the members' behalf. | further updates were required to address this finding. The updates were implemented after the start date of the 2023 DHCS Audit review period.<br>Please note, this policy was updated to also address finding 4.1.1. | » 1.3.1 Sample Case File 20240226 | | **POLICIES AND PROCEDURES**<br>» GA.08 Appeals Policy requires member written consent for processing provider-initiated appeals.<br>**MONITORING AND OVERSIGHT**<br>» 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)<br>» 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 appeals cases without written consent and follow up with individual staff members. (1.3.1 GA-DP.008 Monitoring of Provider Filed Appeals 20230501)<br>**The corrective action plan for finding 1.3.1 is accepted** |
| **1.3.2 Timeframe Change Letters in Expedited Appeals** | By 3/31/2024, the Plan will make the appropriate changes to the Timeframe Change Letter | N/A | 3/31/2024 | The following documentation supports the MCP's efforts to correct this finding:<br>**MONITORING AND OVERISIGHT** |

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| The Plan did not provide information in the written notice about the member's rights to file a grievance if they disagree with the Plan's decision to deny the request for an expedited appeal. | template language and submit for review and approval.<br>Upon regulatory approval, the updated letters will be programmed into the Plan's letter automation systems for immediate use. | | | » Timeframe change Letter Templates demonstrate the MCP has updated it letter templates to notify members of their right to file a grievance if they disagree with the MCP's decision to deny the expedited appeal request. The letter was approved on 9/13/24 (MCAL_110A_Notice+of+Timeframe+Change+Exp+to+Std_REQ_V1 (002), MCAL_110A_Timeframe_Chg_Exp_to_Std_REQ_PRV_V2, MCAL_110A_Timeframe_Chg_Exp_to_Std_REQ_V2, 1.3.2 Expedited Appeal Request Denial - Approved)<br>**The corrective action plan for finding 1.3.2 is accepted.** |
| **1.3.3 Expedited Appeal Requests**<br>An expedited appeal request was downgraded despite the provider submitting evidence that a delay in receiving treatment could seriously jeopardize the member's health. | Finding 1.3.3 states "The Plan did not follow the expedited appeal process when the provider indicated that a delay in receiving treatment could seriously jeopardize the member's health…".<br>Finding 1.3.3 states the Plan "…did not involve a medical director" in the decision to downgrade an expedited appeal to standard appeal. | N/A | N/A | The following documentation supports the MCP's efforts to correct this finding:<br>**POLICIES AND PROCEDURES**<br>» Policy GA.08 Member Appeals Procedure for Medi-Cal, HealthWorx, and ACE updated (4/1/24) was updated by the MCP to instruct that expedited appeals the clinical nurse determines not to meet expedited criteria will be sent to the medical director for final expedited criteria decision. (1.3.3 GA.08 Appeals Policy_v33 20240510)<br>**MONITORING AND OVERSIGHT** |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date * (*Short-Term, Long-Term) | DHCS Comments |
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| | Finding 1.3.3 references language in the Plan's policy GA.08 Member Appeals Procedure for Medi-Cal, HealthWorx and ACE to state that "…requests for an expedited appeal will be immediately reviewed by a Grievance and appeals coordinator and forwarded to the clinical review nurse or a medical director, who will approve or deny the request for the expedited appeal within 72 hours of the Plan's receipt of the request."<br><br>The policy language in GA.08, referenced in the finding, affords the option for either the Plan's Clinical Review Nurse or a Medical Director to approve or deny a request for expedited appeal. As described in the verification study referenced in the Draft Report, the request for an expedited appeal was in fact forwarded to the Plan's | | | » Case Review Checklist demonstrates the MCP updated to confirm whether a case was downgraded and confirm that a Medical Director provided the downgrade decision. (1.3.3 Case Review Checklist - Downgrade Decisions)<br><br>**The corrective action plan for finding 1.3.3 is accepted.** |

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| | Clinical Review Nurse. This is not a deviation from the Plan's written procedures.<br><br>The 2023 Audit Final Report cited no regulatory nor contractual provision that would obligate the Plan to include Medical Director to be mandatorily involved in the decision to approve or deny a request for an expedited appeal. | | | |

## 2. Case Management and Coordination of Care

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date * (*Short-Term, Long-Term) | DHCS Comments |
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| **2.1.1 Coordination of Care with Providers and the Regional Center**<br>The Plan did not ensure care coordination for members with CCS conditions and developmental disabilities. | Care coordination activities between HPSM, CCS, and GGRC is codified in existing policy. These activities are engaged on a regular basis, however they were not adequately documented in 2 of the case files reviewed, as cited in Finding 2.1.1.<br>The CCS team created a supplemental policy which further outlines coordination activities required of them.<br>A GGRC/CCS/HPSM quarterly meeting was held in December 2023, where the kinds of discussions and coordination, outlined in policy, were engaged on. | » 2.1.1 CCS-01 Care Coordination and Case Management (section 6.0 and Related Documents)<br>» 2.1.1 CCS Care Coordination Procedure 20240226<br>» 2.1.1 HPSM GGRC CCS Quarterly Meeting Invite 20240226 | N/A | The following documentation supports the MCP's efforts to correct this finding:<br>**POLICIES AND PROCEDURES**<br>» CCS Care Coordination Procedures from 2/22/24 created by the MCP outlines the care coordination responsibilities of CCS Team. (2.1.1 CCS Care Coordination Procedure 20240226)<br>**MONITORING AND OVERSIGHT**<br>» HPSM and GGRC Meeting Agenda Template demonstrates the MCP, CCS and GGRC review and discuss complex cases (2.1.1 HPSM and Golden Gate Regional Center Meeting Agenda_Template 20240401)<br>» CCS File Review and File Review Process demonstrate the MCP has a process in place to review CCS case files to verify care coordination with GGRC and other entities. The MCP's Care Manager conducts a file review in the MCP's electronic care management record keeping system utilizing the MCP's CCS case file review tool. (2.1.1 CAP HPSM CCS Case File Review Process, 2.1.1 CAP June 2024 CCS Case File Review)<br>**The corrective action plan for finding 2.1.1 is accepted**. |

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| | | | | |
| **2.1.2 Execution of the MOU with the Regional Center**<br>The Plan did not execute the MOU when it did not regularly meet to develop a work plan and discuss administrative and policy issues with the regional center. | As part of Operational Readiness efforts, the Plan is currently engaged with GGRC to adopt the DHCS regional center MOU template, recently released. Current status on MOU work is reported to DHCS. | » 2.1.2 HPSM MOU Quarterly Reporting Template - GGRC 20240226 | Long Term | The following documentation supports the MCP's efforts to correct this finding:<br>MCPs are required to submit quarterly reports to demonstrate their good faith efforts to execute MOUs:<br>» "APL 23-029: Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities" states that MCPs must demonstrate a good faith effort to meet the requirements of this APL. MCPs that are unable to execute their MOUs by the required execution date for MOUs for which DHCS has issued templates, must submit quarterly progress reports and documentation to DHCS demonstrating evidence of their good faith effort to execute the MOU. (APL 23-029, Quarterly Reporting Section, Page 11).<br>» "Managed Care Boilerplate Contract: 5.6.3. - MOU Oversight and Compliance" states that to the extent Contractor does not execute a MOU within the timeframe required under this Contract and relevant APLs, Contractor must submit quarterly reports to DHCS documenting its continuing good faith efforts to execute the MOU, until such time as the MOU is executed. Documentation of good faith efforts must include a description of attempts made to execute an MOU |

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| | | | | and the explanation for why the MOU has not been executed. (Managed Care Boilerplate Contract, 5.6.3. - MOU Oversight and Compliance, B. – MOU Compliance Requirements, Section 2, Page 418).<br>**POLICIES AND PROCEDURES**<br>» "HPSM MOU Quarterly Reporting Template" to demonstrate that the MOU is in progress between the MCP and Regional Center. (HPSM MOU Quarterly Reporting Template - GGRC).<br>» "HPSM and Golden Gate Regional Center Meetings," (2024) Meeting Agenda and Meeting Minutes in which the MCP has established quarterly and monthly meetings with GGRC. The MCP is in the process of developing a Work Plan that will conform with the new MOU template provided by DHCS. The Work Plan is a standing item on the agenda to demonstrate that it continues to be developed. (HPSM and Golden Gate Regional Center Meeting Agenda, HPSM GGRC CCS Meeting Minutes).<br>» MCOD Submission Review Form, "D.0130.F: Revised Regional Center MOU Template" (02/12/24) in which the MCP has submitted a revised Regional Center MOU Template for DHCS review and approval. The MCP's MOU with Golden Gate Regional Center was conditionally approved by DHCS. The MCP is working to address the |

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| | | | | remarks noted in the review form and send the final MOU for execution. The review form did not require the MCP to resubmit the MOU prior to obtaining signatures. (R.0130 Revised MOU Template Review Form HPSM Golden Gate Regional Center).<br><br>**The corrective action plan for finding 2.1.2 is accepted**. |
| **2.1.3 Initial Health Appointment (IHA) Scheduling Attempts**<br><br>The Plan did not conduct and document reasonable and/or sufficient attempts to schedule an IHA for members. | The Plan updated its IHA policy to allow PCPs to document outreach attempts to schedule IHAs in other tracking systems outside of the medical record.<br><br>The Plan updated Initial Health Appointment information in the Provider Manual to provide guidance on the expanded process.<br><br>The Plan incentivizes both the scheduling and completion of the IHA, with inclusion of the IHA in its new Care Gap P4P (with Stellar). Under Stellar/Care Gap P4P, members who are due for an | » 2.1.3 QI-107 Initial Health Appointment 20240226 (section 2.2.2)<br>» 2.1.3 Provider Manual 2024 20240226 (section 9, pgs. 142-143)<br>» 2.1.3 QI-107 Initial Health Appointment 20240226 (section 2.2.2)<br>» 2.1.3 IHA Provider Training Guide 20240226<br>» 2.1.3 IHA Provider Training and Attestation 20240226 | 9/1/2023<br>1/1/2024<br>2/17/2024 | The following documentation supports the MCP's efforts to correct this finding:<br><br>**POLICIES AND PROCEDURES**<br><br>» The Plan updated Policy & Procedure Manual, Procedure No. QI-107, Revised 2/17/2024, Page 1, Section 2.2.2, which has been amended to include a section on conducting and documenting reasonable attempts to schedule an IHA. The section includes a guideline for PCPs on monitoring the process to demonstrate that sufficient attempts are made for all members. The amendments to the P&Ps address the IHA timelines and contractual requirements. (QI-107 Initial Health Appointment 20240226)<br>» HPSM Provider Manual was revised to include guidance on the process of updated IHA information, which outlines the requirement for PCPs to make at least three documented |

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| | IHA are assigned a time-based tag that visually marks and makes available for filtering patients in care gap registries. This tag is applied to patients as part of the 3-step Annual Visit Action Center, which requires 1) attesting to scheduling, 2) attesting to completing, and 3) claims confirming a 1-per-calendar-year visit. All eligible members assigned to the practice are eligible for this bonus payment. Providers can use a feature within the Stellar platform on the Annual Visit scheduling action to enter outreach log notes for each eligible patient.<br><br>Under MY2024, Benchmark P4P IHA remains a payment metric for Family Practice and Adult Track providers and reporting-only for Pediatric providers. This is based | » 2.1.3 2024 Care Gap P4P Guidelines 20240226 (page 6) | | attempts to contact and schedule an IHA for a member. The attempts must include at least one telephone contact and one written contact. (Provider Manual 2024 20240226, Page 142-143, "Components of an IHA")<br><br>**TRAINING**<br><br>» HPSM's Initial Health Appointment (IHA) Training Guide, Scheduling IHAs, as evidence that the Plan's contracted providers receive guidance on attempts to schedule IHAs and documentation of said attempts. Efforts to contact members must include at least one telephone contact and one written contact. If the provider is unable to reach a member or a member refuses an appointment, this information is documented and HPSM Member Services will be contacted for assistance. The Training Guide includes a signature block for PCPs as an attestation they have read the training material and understand the requirements. (IHA Provider Training Guide 20240226)<br><br>**MONITORING AND OVERSIGHT**<br><br>» IHA Outreach Log demonstrates IHA scheduling attempts are tracked by PCPs. Log includes Member ID number, Member Name, Dates of Outreach and Means of Outreach. Logs are reviewed by the Plan's QI RNs. (IHA Outreach Log_Redacted 20240610) |

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| | on prioritization in assigned quality metric sets. | | | **The correction action plan for finding 2.1.3 is accepted.** |
| **2.1.4 Blood Lead Screening Member Outreach Attempts for Pediatric Members**<br>The Plan did not ensure that blood lead screening attempts were conducted for members up to six years old. | The Plan updated policy QI-122 Blood Lead Screening of Young Children to include documentation of unsuccessful attempts to provide the required blood lead screening test results in the member's medical record.<br>The Plan sends monthly Well Visit Reminder mailers to members turning 3-6 years old, which includes reference to Blood Lead Screening.<br>The Plan's Spring 2023 Member Newsletter contained information on the importance of Blood Lead Screening. In June 2023, the Plan included a DHCS pamphlet speaking to Lead Poisoning in a member mailing. | » 2.1.4 Member and Provider Information - Lead Screening 20240226 | 3/1/2024<br>Spring 2023<br>4/24/2024<br>2/2023; 9/2023<br>3/26/2024 | The following documentation supports the MCP's efforts to correct this finding:<br>**POLICIES AND PROCEDURES**<br>» Updated P&P, "QI-122: Blood Lead Screening of Young Children" (02/20/2024) which states that the provider documents all unsuccessful attempts to provide the required blood lead screening tests in the member's medical record. (QI-122 Blood Lead Screening of Young Children, Page 2).<br>» Mailer, "Well Visit Reminder" as evidence that the MCP sends reminders to members about blood lead screenings on a monthly basis. This reminder is meant to encourage the members to speak to their child's PCP as another opportunity for the PCP to connect on specific needs, including blood lead screening. (Well Child Mailer 2024).<br>» Program Guidelines, "HPSM Care Gap Closure Pay-for-Performance Pilot" (May 2024) as evidence that the MCP has established a pay-for-performance program for blood lead screening. Providers are paid a total incentive per member |

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| | The upcoming Spring 2024 Member Newsletter will again contain an article on the importance of Blood Lead Screening and encourage members to schedule an appointment with their PCP. Postpartum members enrolled in the Plan's Baby+Me program will receive Well-Child kits containing information on ways to protect children from lead poisoning. This is expected to be distributed in June 2024.<br><br>The Plan's Winter 2022 Provider Newsletter contained an article regarding lead screening and referenced clinical guidelines. The Plan distributed a Provider Notification in February 2023 informing providers that Lead Test Kits were available for screenings. In September 2023, the Plan reviewed and approved Clinical | | | for attesting to completing and reviewing completion of blood lead screening and when the MCP receives an associated claim. (2024 Care-Gap P4P Guidelines).<br><br>**TRAINING**<br><br>» Provider Newsletter, "Health Matters – Perform Blood Lead Screening on Children" (May 2024) which states that providers have a responsibility to inform parents that children can be harmed by exposure to lead and to provide this anticipatory guidance to parents with children starting at six months and up to six years old. (Provider Newsletter - Blood Lead Screening Excerpt).<br><br>**MONITORING AND OVERSIGHT**<br><br>» P&P, "QI-122: Blood Lead Screening of Young Children" (02/20/2024) which states that the MCP monitors provider adherence to contractual requirements, including BLLs as defined in this policy and APL 20-016 through the FSR/MRR process. (QI-122 Blood Lead Screening of Young Children, Page 3).<br><br>» Sample, "MRR Score Sheet" (January 2024) as evidence that the MCP monitors for blood lead screening through the FSR/MRR process. Provider would score a "0" on the medical record review on the blood lead screening component if BLS test or attempted BLS test documentation |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date * (*Short-Term, Long-Term) | DHCS Comments |
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| | Guidelines that included Lead Screening; these guidelines are listed as a provider resource on its website.<br><br>The Plan's upcoming March Provider Newsletter will contain information on Blood Lead Screening and the updated guidelines from the September 2023 review.<br><br>Blood Lead Screening remains a reporting-only metric for the Plan's MY2024 Benchmark Pay-for-Performance (P4P) Program; Providers have access to templated performance reports through at least April 2025. Blood Lead Screening in Children (LSC) is a payment-bearing 2-step action in Care Gap P4P (Stellar). Enrolled providers are paid a total incentive per member for 1) attesting to completing/reviewing completion of LSC and when 2) | | | is not found in the medical record. (Sample MRR Score Sheet, Page 3).<br><br>» Written Statement from the MCP (05/01/2024) which states that while the Facility Site Review/Medical Record Review (FSR/MRR) process is performed once every three years at minimum for contracted PCP, interim monitoring can be conducted on a more frequent basis with a focused reviews on identified areas of deficiency. Interim focused reviews are often conducted for MRR deficiencies 12-18 months from MRR to allow PCPs time to fully implement MR documentation corrections.<br><br>» "Blood Lead Screen 2023 Report" as evidence that the MCP has a process to monitor blood screening compliance across its membership annually, including a review of sample medical records. (Blood Lead Screen 2023 Report).<br><br>» "In-Service Form – Blood Lead Screening" which contains all the training topics related to the identified deficiencies. The CAP for deficiencies related to the blood lead screening requires the provider to submit a copy of the in-service outline (agenda) and a sign in sheet demonstrating attendance of the blood lead screening in service. (Signed In-Service Form BLS example).<br><br>**The corrective action plan for finding 2.1.4 is accepted.** |

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| | HPSM receives an associated claim. | | | |
| **2.3.1 Behavioral Health Treatment Plan Criteria**<br>The Plan did not ensure members' behavioral treatment plans contained all the required criteria. | Please refer to Attachment B. | N/A | N/A | The following documentation supports the MCP's efforts to correct this finding:<br>**MONITORING AND OVERSIGHT**<br>» "BHT Care Plan Audit Tool" and "Job Aid – BHT Care Plan Audit Tool" as evidence that the MCP implemented a monitoring process to track that the member's behavioral treatment plans contain all the required criteria including but not limited to, an estimated date of mastery for goals and a crisis plan. The Plan will collect 10 sample case files monthly from Magellan. The files will be reviewed to confirm they contain Dates of Mastery, Crisis Plan, and confirm that the member was offered and/or received the appropriate services in accordance with their approved behavioral treatment plans. (BHT Care Plan Audit Tool, Job Aid – BHT Care Plan Audit Tool).<br>**The corrective action plan for finding 2.3.1 is accepted.** |
| **2.3.2 Provision of Behavioral Health Treatment Services** | Please refer to Attachment B. | N/A | N/A | The following documentation supports the MCP's efforts to correct this finding:<br>**MONITORING AND OVERSIGHT** |

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| The Plan did not ensure the provision of BHT services to members in accordance with their approved behavioral treatment plans. | | | | » "BHT Care Plan Audit Tool" and "Job Aid – BHT Care Plan Audit Tool" as evidence that the MCP implemented a monitoring process to track that the member's behavioral treatment plans contain all the required criteria including but not limited to, an estimated date of mastery for goals and a crisis plan. The Plan will collect 10 sample case files monthly from Magellan. The files will be reviewed to confirm they contain Dates of Mastery, Crisis Plan, and confirm that the member was offered and/or received the appropriate services in accordance with their approved behavioral treatment plans. (BHT Care Plan Audit Tool, Job Aid – BHT Care Plan Audit Tool).<br>**The corrective action plan for finding 2.3.2 is accepted.** |
| **2.4.1 Continuity of Care Request Completion within Required Timeframes**<br>The Plan did not ensure members' COC requests were | In response to the finding, the Plan implemented internal process enhancements within the Provider Services team, including a monitoring process dedicated to tracking and communicating the status of Continuity of Care Requests (CoCs) during weekly Provider Services meetings. Additionally, we have conducted | » 2.4.1 CoC Request Monitoring Job Aid 20240226<br>» 2.4.1 CoC Request Tracking Report 20240226 | Q4 2023 | The following documentation supports the MCP's efforts to correct this finding:<br>**POLICIES AND PROCEDURES**<br>» Job Aid, "Provider Services" (02/26/24) demonstrates the Plan created a job aid to document the COC request monitoring process.<br>» Newly Developed Procedure, "PS JA-01 Monitoring Continuity of Care Requests" (05/10/24) demonstrates the |

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| completed within the required timeframes. | cross-training for all Provider Network Liaisons to handle CoC requests timely. | | | Plan has developed and implemented procedures to make certain that COC requests for members are completed within the required timeframes. Per Plan response, "The Plan established a 95% timeliness rate goal for COC requests".<br>**MONITORING AND OVERSIGHT**<br>» Report, "COC Request Tracking Report" (02/26/24) per Plan response, "Given current limitations in the ticketing system, COC timeliness monitoring is a manual process; the dashboard shown in the screenshot provided is not able to indicate timeliness on a single screen. Tracking timeliness based on priority level requires the Provider Services Manager to open each ticket to track priority level and date of request closure".<br>» Report, "COC List Report" (08/23 - 04/24) demonstrates the Plan sent this COC List report to DHCS as part of its Dental Integration filing. The Plan will utilize this report as part of its COC monitoring activities, including weekly staff check-ins, moving forward. The COC Case List provided examples current compliance with COC case timeliness. The report provided tracks all COC requests, not just Dental.<br>» Report, "COC List Report" (01/24 - 05/24) demonstrates the Plan is consistently monitoring for compliance with COC case timeliness. |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date * (*Short-Term, Long-Term) | DHCS Comments |
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| | | | | **TRAINING**<br>» Training, "Continuity of Care" (05/21/24) demonstrates the Plan provided training to staff utilizing Policy PS-05, on the importance of ensuring members' COC requests are completed within the required timeframes and provide evidence in its June response. Attestations received.<br>**The corrective action plan for finding 2.4.1 is accepted.** |

## 3. Access and Availability of Care

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date * (*Short-Term, Long-Term) | DHCS Comments |
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| **3.1.1 Timely Appointment Standard for Dental Providers**<br>The Plan did not monitor timely access for appointments with dental providers. | The Plan made updates to its Timely Access and Network Adequacy policy to reflect implementation of a new self-monitoring process. See Section 6.0 for process description and 6.3.6 for specific identification of 'dental' as an included provider type. The Plan will identify, sample, and survey network dental providers pursuant to the same methodology assigned to other provider types under PAAS.<br>The Plan began collecting dental provider appointment availability data under the new process in December 2023. Dental Provider Raw Data and Results analysis will be provided in a future CAP response.<br>The Plan will evaluate the new self-monitoring process when finalizing | » 3.1.1 PS 06-01 Timely Access and Network Adequacy 20240226 | 1/16/2024 | The following documentation supports the MCP's efforts to correct this finding:<br>**POLICIES AND PROCEDURES**<br>» Revised P&P, PS 06-01, "Timely Access and Network Adequacy" (01/16/24) demonstrates the Plan has added additional non-PAAS provider types which includes Dental to the annual Timely Access Survey to determine appointment availability an calculate the rate of compliance/non-compliance across provider types and networks. In addition, if non-compliance is identified, the Plan will issue a letter of reprimand to provider and corrective action plan, up to and including termination from the network, and Plan will prioritize network development and expansion in the affected provider type.<br>**MONITORING AND OVERSIGHT**<br>» Org Chart, "Provider Services" (02/07/24) as evidence that the Manager of Strategic Network investments is responsible for executing the PAAS submission and reports directly to the Director of Provider Services.<br>» Monitoring Results, "MY2023 Dental PAAS Raw Data and Results 20240510", (12/2023 and 01/2024) demonstrates the |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date * (*Short-Term, Long-Term) | DHCS Comments |
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| | the processing and validation of the PAAS Raw Data in April 2024. | | | Plan is monitoring timely access for appointments with Dental Providers.<br>**The corrective action plan for finding 3.1.1 is accepted.** |
| **3.1.2 Monitoring Extended Appointment Timeframes**<br>The Plan did not monitor whether providers documented in the medical record that extended appointment timeframes would not be detrimental to members' health. | Effective 3/1/2024, HPSM will integrate monitoring of medical record documentation of extended appointment timeframes into its existing PQI process. When extended appointments are identified through grievances and PQI identification processes, HPSM will request medical records from the provider for the identified member. Medical records will be reviewed by the Medical/Dental Director for documentation of the impact of the extended appointment timeframe on the member's health. If the reviewing Medical/Dental Director does not find documentation that the extended appointment time will not have a detrimental impact on | » 3.1.2 QI-103 Review and Handling of Potential Quality Issues and Quality of Care Concerns 20240226<br>» 3.1.2 PQI Notice of Resolution Letter Template 20240226<br>» 3.1.2 HPSM Provider Manual 20240226 | 3/1/2023<br>4/2024 | The following documentation supports the MCP's efforts to correct this finding:<br>**POLICIES AND PROCEDURES**<br>» "QI-103 Review and Handling of Potential Quality Issues and Quality of Care Concerns 20240226" provides evidence the actions taken by the Plan for deficiencies identified including, provider education, implementing CAPs & escalating disciplinary actions. (QI.103, Procedure, 3.7 & 3.8, pages 4 & 5)<br>**OVERSIGHT AND MONITORING**<br>» "QI-103 Review and Handling of Potential Quality Issues and Quality of Care Concerns 20240226" demonstrates the Plan's review process of identifying whether providers have documented in the medical record that extended appointment timeframes will not have a detrimental impact on the member's health. Medical records are reviewed by the Medical/Dental Director for documentation of the impact of the extended appointment timeframe on the member's |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date * (*Short-Term, Long-Term) | DHCS Comments |
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| | the member's health, a statement educating the provider of the medical record documentation requirement will be added to the PQI resolution letter and the Timely Access to Care Fact Sheet will be enclosed with the PQI resolution correspondence.<br><br>The Plan will include information on the extended appointment timeframe medical record documentation requirement in an upcoming fax notification related to timely access appointment availability standards to network providers, expected to be released in April 2024.<br><br>The Plan's Provider Manual explains the requirement for providers to document extended appointment impact on a member in their medical record, pgs. 132-135. | | | health. If the reviewing Medical/Dental Director does not find documentation that the extended appointment time will not have a detrimental impact on the member's health, a statement educating the provider of the medical record documentation requirement will be added to the PQI resolution letter & the Timely Access to Care Fact Sheet will be enclosed with the PQI resolution correspondence. The policy also provides evidence of other actions the Plan will take for deficiencies identified as implementing CAPs & escalating disciplinary actions. (QI.103, Procedure, 1.0 & 3.0, pages 2-5)<br><br>**TRAINING**<br><br>» "3.1.2 HPSM Provider Manual 20240226" is evidence of the Plan making providers aware of the requirement to document in the medical record that the extended appointment timeframe was not detrimental to the member's health. (2024 Provider Manual, pages 132-135)<br><br>» "3.1.2 Provider Timely Access Requirements Notification 2024 0510" demonstrates the Plan's annual reminder of the requirement to document that the extended appointment timeframe was not detrimental to the member's health.<br><br>**The corrective action plan for finding 3.1.2 is accepted.** |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date * (*Short-Term, Long-Term) | DHCS Comments |
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| **3.8.1 Non-Emergency Medical Transportation Prior Authorization**<br>The Plan did not consistently require prior authorizations for NEMT services and did not use PCS forms to determine the appropriate level of services. | The Plan is continuing internal discussion to finalize updated processes and controls to ensure compliance with APL requirements. | TBD | TBD | The following documentation supports the MCP's efforts to correct this finding:<br>**POLICIES AND PROCEDURES**<br>» "3.8.1 UM.013 Non-Emergency Medical Transportation20240510" is evidence of the Plan making providers aware of the requirement to submit a completed PCS form prior to NEMT being provided & the PCS form will be utilized in order to determine the appropriate level of services. (UM.013 Non-Emergency Medical Transportation, Procedure, 3.5 & 3.7, page 3)<br>**MONITORING AND OVERSIGHT**<br>» "3.8.1 UM.013 Non-Emergency Medical Transportation20240510" is evidence of the Plan making providers aware that the Plan is responsible for coordinating the NEMT service request based on medical necessity/level of service needed. (UM.013 Non-Emergency Medical Transportation, Responsibility and Authority, page 1)<br>» The Plan has a system that automatically rejects PAs submitted for NEMT rides that do not include a PCS form. The system will capture PCS forms as "were submitted prior to the claim payment" written to highlight that the claim was |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date * (*Short-Term, Long-Term) | DHCS Comments |
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| | | | | paid with a valid PA/PCS form on file. (See Attachment B, May Response, 3.8.1)<br>**The corrective action plan for finding 3.8.1 is accepted.** |
| **3.8.2 Transportation Liaison**<br>The Plan did not have a direct line to the Plan's transportation liaison for members and providers. | The Plan will publish updated Transportation Liaison contact information in its upcoming Member Newsletter (by 6/30/24), Provider Newsletter (by 6/30/24), Plan Website (by 5/31/24), and future annual EOC update (by 12/31/24). | » 3.8.2 Transportation Liaison Contact Publication 20240226 | 6/30/2024 | The following documentation supports the MCP's efforts to correct this finding:<br>The Plan's root cause analysis for this finding "...At the time of this audit, the Plan's Transporation Liaison was still in training; therefore, a direct point of contact to members and/or providers was not yet available."<br>**POLICIES AND PROCEDURES**<br>» "3.8.2 Transportation Liaison Contact Publication" is evidence that the Plan published transportation liaison contact information on its provider website, member newsletter & member materials.<br>**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 |
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| **4.1.1 Grievance Written Consent**<br>The Plan did not obtain member written consent for grievances filed on behalf of a member. | The Plan updated its grievance policy to align member written consent requirements across both grievances and appeals processes. Because of the pre-existing process on the appeals side, this change required no updates to complaint processing or monitoring workflows. Please reference section 3.4 in GA.07 Grievance Policy.<br>Staff were notified/trained on the policy change on January 8, 2024. | » 4.1.1 GA.07 Grievance Policy 20240226<br>» 4.1.1 G&A Staff Meeting 20240108 Agenda 20240226 | 1/1/2024<br>1/8/2024 | The following documentation supports the MCP's efforts to correct this finding:<br>**POLICIES AND PROCEDURES**<br>» Revised P&P, "GA.07: Member Grievance Procedure for Medi-Cal, HealthWorx, and ACE" (01/01/24) which has been revised to include, "Members, or a Provider or authorized representative acting on behalf of a member and with the Member's written consent, may file a Grievance, or request an Appeal, either orally or in writing". (4.1.1 GA.07 Grievance Policy 20240610.docx)<br>» Plan Response, "Any non-compliance with G&A processes would be addressed on an individual basis with the affected staff, and often addressed on a department basis, with all G&A staff, during a G&A staff meeting, if warranted".<br>**MONITORING AND OVERSIGHT**<br>» Dashboard Screenshot, "Case Review Dashboard" demonstrates the Plan has a system in place to monitor if an AOR form has been received when a representative wants to file a grievance on member's behalf. In addition, the G&A Supervisor utilizes the dashboard, regularly and in real-time, to identify cases that require written consent, flagged as "Pending AOR". That flag is an indicator for the Supervisor to |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date * (*Short-Term, Long-Term) | DHCS Comments |
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| | | | | continually review the case, until it is closed, to track the status of the attempts to receive consent. The Supervisor is able to provide immediate feedback and/or support to the coordinator(s) to demonstrate appropriate rates of completion. (4.1.1 Case Review Dashboard 20240610.docx) and (4.1.1 Grievances_Weekly Cases Due 20240701)<br>» Plan Response, "Any non-compliance with G&A processes would be addressed on an individual basis with the affected staff, and often addressed on a department basis, with all G&A staff, during a G&A staff meeting, if warranted".<br>**TRAINING**<br>» Staff Training, "Grievance and Appeal Staff Meeting Agenda" (01/08/2024) demonstrates the Plan provided training on the new process on MC Grievances filed by representative effective 01/01/24.<br>**The corrective action plan for finding 4.1.1 is accepted**. |
| **4.1.2 Translation of Grievance and Appeals Notices**<br>The Plan did not ensure that all | The Plan previously explained in the Draft Audit Report Response provided to DHCS A&I on 1/10/2024, the issues concerning the translated attachments | » 4.1.2 Sample Case File 1 20240226<br>» 4.1.2 Sample Case File 2 20240226 | 6/2023 | The following documentation supports the MCP's efforts to correct this finding:<br>**POLICIES AND PROCEDURES**<br>» P&P, GA.10, "Overview of Member Complaints Process for Medi-Cal, HealthWorx, and ACE" (03/01/24) demonstrates |

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| grievance and appeals letters were correctly translated into members' threshold language. | presenting erroneous characters were self-identified through HPSM's existing monitoring and internal auditing activities and had been rectified prior to DHCS conducting the 2023 Routine Audit. | | | the MCP reviews all resolutions by the Grievance and Appeals Manager prior to sending to the member. In addition, the Chief Health Officer is the Officer designated with primary responsibility for overseeing the Grievance and Appeals Unit and processes. The Director of Customer Support, in conjunction with the Grievance and Appeals Manager, is responsible for continuously reviewing the operation of the G&A Unit to identify areas of improvement and emerging patterns.<br>» P&P, PH.205, "Translation Procedures" (06/30/22) demonstrates the MCP has a translation process to make certain that all written member materials (all lines of business) that require translation are given to a contracted translation vendor for translation. Additionally, vendors are selected based on a review of translator proficiency standards, quality assurance process, sample translation, and references. Translators must be monitored for quality on an ongoing basis and be provided with training as necessary to correct deficiencies. All translators must meet proficiency standards.<br>**MONITORING AND OVERSIGHT**<br>» The Director of Compliance and the Government and Regulatory Affairs manager worked in partnership to implement the new oversight auditing program. The |

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| | | | | Government and Regulatory Affairs Manager regularly engages with their Internal Auditors, either through reoccurring one-on-one meetings or ad-hoc meetings, to discuss day-to-day internal auditing functions. The consistent adherence to internal audit process, including the audit tool and appropriate documentation within the audit report and CAP responses, is one of the many aspects of day-to-day audit operations that were discussed when implementing the new oversight auditing program.<br><br>Internal auditing is a routine course of Compliance function, and each unit is audited on an annual basis.<br><br>» Pre-Audit Letter, "Annual Internal Audit of Medi-Cal Grievances and Appeals" (10/04/23) demonstrates the Plan provided a letter to the Grievance and Appeal Department outlining what to expect with the annual internal oversight audit.<br><br>» Post Audit Closure Letter, "Delegation Oversight Annual Grievances and Appeals" (05/13/24) demonstrates the Plan conducted a desktop audit of Grievance and Appeals Department functions on 11/02/2023 - 11/12/2023. The audit period was 01/01/23 - 06/30/23. The Plan focused on reviewing Grievances to make certain language and accessibly such as large print and language request for resolution letters are sent accurately, and resolution letters |

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| | | | | are clear and concise. In addition, the policies and procedures were reviewed, which included, Operations, Grievance and Appeals department staff list, and Training Materials.<br>» Audit Findings, "Member Services Grievance and Appeals Attachment A, Closed CAP" (11/30/23 CAP Issue Date) demonstrates the Plan issued a CAP to the Grievance and Appeals Department. A total of 10 deficiencies were identified and a Corrective Action Plan (CAP) was issued to the Grievance and Appeals Department on 11/30/23. The Plan thoroughly reviewed the documentation of remediation and evidence provided by the G&A Department through the CAP process. The G&A Department did meet all requirements in response to the CAP.<br>**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 |
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| **5.1.1 Quality Improvement System**<br>The Plan did not adequately evaluate and/or take timely action in its PQI process to address needed improvements in the quality of care delivered by providers. | Beginning September 2023, the Plan's QI Manager conducted in-depth analysis and met with key teams involved in PQI processing (G&A, Medical Directors, Provider Services) to identify gaps in the PQI process. As a result, the Plan updated its PQI policy; these updates codify PQI timeframes and establish an escalation process to address non-responsive providers. See sections QI-103, sections 3.0-4.6.<br>The Plan also created a workflow to establish a fluid process between G&A and QI, for PQI QOCs, particularly to address providers that are not responsive.<br>QI Manager established weekly PQI Meetings within the Quality Improvement department to improve oversight and monitoring of PQIs. | » 5.1.1 QI-103 Review and Handling of Potential Quality Issues and Quality of Care Concerns 20240226<br>» 5.1.1 PQI Grievance QOC - No Provider Response Process 20240226<br>» 5.1.1 PQI Priority Email 20240226 | 12/1/2023<br>2/1/2024; 12/1/2023<br>12/1/2023 | The following documentation supports the MCP's efforts to correct this finding:<br>**POLICIES AND PROCEDURES**<br>» Plan submitted revised Policy QI-103 Review and Handling of Potential Quality Issues and Quality of Care Concerns (11/20/23) that establishes PQI investigation timeframes and escalation process (Sections 3.0 - 4.6).<br>» Plan developed a workflow, PQI Grievance QOC - No Provider Process that addresses Plan process when providers are not responsive.<br>**MONITORING AND OVERSIGHT**<br>» Plan has established weekly PQI meetings within the QI Department to improve oversight and monitoring of PQIs.<br>» Weekly reports are pulled to support monitoring.<br>» PQI Report Template (blank). Plan submitted evidence of implementation of PQI Report. Report includes case status, description, resolution, type, and severity level scoring.<br>» Plan submitted redacted copies of weekly huddle meeting minutes and PQI reports as evidence of discussion and PQI follow up. PQI Priority Emails serve as the weekly meeting |

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| | Weekly reports are pulled to support monitoring.<br>Additionally, the QI Manager conducted overhauling efforts to assist the Plan's G&A department with processing to reduce PQI backlog and assisted the CRN in G&A to complete outstanding reviews. | | | minutes and provide evidence of case discussion and follow up.<br>» Plan submitted evidence of implementation of Medical Quality Review Group MRQG meeting minutes.<br>**The corrective action for finding 5.1.1 is accepted.** |
| **5.2.1 (Rpt. of 5.2.1 2022) Ownership and Control Disclosure**<br>The Plan did not ensure that its subcontractors submitted complete ownership and control disclosure information. | The Plan has continued efforts to collect the remaining ownership and disclosure forms; Dignity's Form provided in this response completes that activity.<br>As mentioned during the 2022 CAP process, UCSF refuses to provide the necessary information citing 1) the regulation does not apply to them due to the nature in which the entity was established and 2) providing such information, as interpreted by DHCS, would include the personal | » 5.2.1 HPSM - Medi-Cal Disclosure Form (Dignity) 20240226 | 2/2023 | The following documentation supports the MCP's efforts to correct this finding:<br>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.<br>Federal regulations and DHCS authorities require Medi-Cal managed care plans (MCPs) to obtain and provide to DHCS certain information, including dates of birth and social security numbers, relating to all persons with an "ownership or control interest" in the MCP's subcontractors and all "managing employees" of those subcontractors. These disclosure |

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| | information of the Governor of California. | | | requirements include subcontractors' board of directors and governing entity members who fall into these categories. These disclosure requirements apply to all subcontractors and is an essential component of Medi-Cal program integrity. Compliance with these disclosure requirements is an explicit condition for receiving Medicaid dollars and failure to comply may lead to sanctions.<br><br>MCPs must demonstrate, through their contracts with any subcontractors, that subcontractors provide written disclosures of information on ownership and control as required under 42 CFR 455.104.<br><br>MCPs must require and demonstrate subcontractors accurately provide all required information in their disclosures. This information includes the date of birth, social security number, and address for each person with an ownership or control interest and for each managing employee.<br><br>MCPs must alert their Managed Care Operations Division (MCOD) Contract Manager within ten (10) working days upon discovery that a subcontractor is non-compliant with these requirements or if a disclosure reveals any potential violations of the ownership and control requirements.<br><br>**The corrective action for finding 5.2.1 is accepted.** |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date * (*Short-Term, Long-Term) | DHCS Comments |
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| **5.3.1 (Rpt. of 5.3.1 2022) Delegation of Provider Training**<br>The Plan did not specify provider training responsibilities in its written agreements with subcontractors. | Please see Supporting Documentation. | » 5.3.1 Magellan Health Inc Amend 9 20240226 | Long Term | The following documentation supports the MCP's efforts to correct this finding:<br>**POLICIES AND PROCEDURES**<br>» 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)<br>» 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.<br>**TRAINING** |

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| | | | | » 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 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)<br>**MONITORING AND OVERSIGHT**<br>» 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)<br>» 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 |

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| | | | | review committee. (PS 01-03 Provider Training, Page 2, Section 1.5.2)<br>» "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).<br>» "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).<br>**The corrective action plan for finding 5.3.1 is accepted.** |

## 6. Administrative and Organizational Capacity

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date * (*Short-Term, Long-Term) | DHCS Comments |
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| **6.2.1 Fraud and Abuse Reporting**<br>The Plan did not complete and report to DHCS the results of preliminary investigations of suspected fraud and abuse incidents within ten working days. | HPSM Procedure CP-DP.002 Fraud, Waste, and Abuse Incident Investigation and Reporting was submitted to, and approved 11/14/2022 by, the DHCS Operational Readiness review team and conforms to the necessary regulatory requirements. Section 8.1.1 outlines the regulatory timeframes in which reporting is required to abide by. The implementation of the Policy was in place prior to the 2023 DHCS Routine Audit, however consistency in monitoring/oversight was the root cause of FWA cases being reported to DHCS beyond the required timeframe.<br>The Plan utilizes a FWA case tracker, which was in place prior to the 2023 DHCS Routine Audit, to monitoring/oversight mechanism. Due to staff attrition, the Plan is currently recruiting for a Compliance Manager. The Compliance Manager will be | » 6.2.1 CP-DP.002 FWA Incident Investigation and Reporting 20240226 | 1/1/2024 | The following documentation supports the MCP's efforts to correct this finding:<br>**POLICIES AND PROCEDURES**<br>» Plan Policy "CP-DP.002: FWA Incident Investigation and Reporting" (revised 07/20/2022), approved by DHCS 11/14/2022, already contained the necessary regulatory requirements and language which conform to the necessary regulatory requirements that outline the timeframes the MCP is required to abide by (see Sections 8.1.1 and 8.1.1.1, pages 4-5, of 6.2.1 CP-DP.002 FWA Incident Investigation and Reporting). The policy outlines the reporting of potential FWA to DHCS within ten working days from the date of discovery or when it is notified of such activity. (6.2.1 CP-DP.002 FWA Incident Investigation and Reporting 20240510, page 6)<br>» The MCP submits on a quarterly basis a report to DHCS PIU of all FWA investigative activities within 10 working days of the close of every calendar quarter, and includes statuses of preliminary, active and completed investigations of FWA (6.2.1 CP-DP.002 FWA Incident Investigation and Reporting, Section 8.1.3, page 5).<br>**MONITORING AND OVERSIGHT**<br>» The MCP's Tracking Log (6.2.1 2024 FWA Tracking Log 20240510) submitted to demonstrate internal monitoring. The staff follow-up with manager to demonstrate adherence to required timeframes. |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date * (*Short-Term, Long-Term) | DHCS Comments |
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| | responsible for monitoring/oversight of timely filings. As an interim means to ensure oversight/monitoring of FWA activities, while recruitment for a Compliance Manager is completed, the Government and Regulatory Affairs Manager meets weekly with the staff assigned to FWA and reviews the tracker to ensure reporting timeliness. The monitoring/oversight function will be the responsibility of the Compliance Manager once the position it is backfilled. | | | The MCP's Government and Regulatory Affairs Manager holds weekly meetings with staff assigned to FWA to review tracker and that required reporting timelines are being met.<br>**The corrective action plan for finding 6.2.1 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:** Brandy Armenta

**Title:** Director of Compliance

**Signed by:** [Signature on file]

**Date:** 02/28/2024