CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

December 29, 2025

Betty Clark, Chief Regulatory Affairs and Compliance Officer *Via E-mail*
Health Plan of San Joaquin
7751 S. Matheny Road
French Camp, CA 95231

RE: Department of Health Care Services Medical Audit

Dear Ms. Clark:

The Department of Health Care Services (DHCS), Audits and Investigations Division, conducted an on-site Medical Audit of Health Plan of San Joaquin, a Managed Care Plan (MCP), from October 28, 2024 through November 8, 2024. The audit covered the period from August 1, 2023, through July 31, 2024.

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. The 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 DHCS from taking additional actions it deems necessary to address 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 the final CAP remediation document (Attachment A) will be made available on the DHCS website and to the public upon request.

If you have any questions, please contact CAP Compliance personnel.

Sincerely,

[Signature on file]
Grace McGeough, Chief
Process Compliance Section
Managed Care Monitoring Branch
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

Enclosures: Attachment A (CAP Response Form)

cc: Kelli Mendenhall, Branch Chief *Via E-mail*
Managed Care Monitoring Branch
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

Lyubov Poonka, Unit Chief *Via E-mail*
Audit Monitoring Unit
Process Compliance Section
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

Christina Viernes, Lead Analyst *Via E-mail*
Audit Monitoring Unit
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Arianna Ngo, Unit Chief *Via E-mail*
Managed Care Contract Oversight Branch
DHCS – Managed Care Operations Division (MCOD)

Travis Romo, 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 Joaquin **Review Period: 08/01/23 – 07/31/24**

Audit: DHCS Medical Audit **On-site Review: 10/28/24 – 11/08/24**

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 Review of Services Exempt from Prior Authorization The Plan incorrectly applied PA requirements to preventive services and cancer biomarker testing.	**1. Revise policies and procedures that address benefit end to end implementation.** a. This process improvement is meant to align with the updates that are occurring in our core billing system. (On Track) **2. Interdepartmental Collaboration and Training:** a. Configuration team is currently reviewing all Medi-Cal Benefits in the core claim billing system with Medical Management team for proper prior authorization requirements. Review of benefits in core billing systems began 04/23/2025. We are updating our systems accordingly with proper prior authorization requirements. (On Track) **3. Internal Auditing and Monitoring** a. Claims QA team will audit claims		1. 06/30/2025 (Short-Term) 2. Initiated 04/23/2025 (Short-Term) 3. a. 06/01/2025 (Short-Term) b. Initiated – 05/02/2025 (Short-Term)	The following documentation supports the MCP's efforts to correct this finding. **POLICIES AND PROCEDURES** » Policy BA01 Medi-Cal Benefit End-to-End Load Policy Rev. date 3/19/25 has been revised to ensure the Plan has an end-to-end process for loading Medi-Cal and Medicare benefits to meet regulatory requirements. This includes a weekly review of new, updated, or termed benefits, through which updates are compiled, analyzed, and operationalized across the organization and in compliance with applicable regulatory requirements. This is done through state Benefit Bulletins, All Plan Letters, State Plan Amendments, or other notices provided by the Department of Health Care Services, the Department of Managed Care Services, Centers for Medicare and Medicaid Services, or other regulatory entities. (1.2.1 and 3.6.1_BA01 Medi-Cal Benefit End-to-End Load Policy_redline_CAP_7_25_25). » Policy UM01 Authorization and Referral Review contains language that states prior authorization is not required for preventative services and cancer biomarker testing. (1.2.1 and 3.6.1_UM01 Authorization and Referral Review – Clean) **TRAINING**

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	for proper claims processing according to the benefit and configuration set rules. Additional reports will be added to include specifics around biomarker testing and preventive services. (On Track)			» The final BRAC Meeting of 6/24/25 demonstrates that staff from Claims, Configuration, and Benefits Administration were trained on updated roles and responsibilities, as well as workflow. (1.2.1 and 3.6.1 Final BRAC Meeting) **MONITORING** » BRAC Weekly meeting invitation demonstrates that the MCP has initiated a weekly meeting series to address benefit updates. Claims, configuration, and Benefits Administration are all part of these meetings. The meeting series began on 5/5/25. (1.2.1 and 3.6.1_BRAC Weekly Meeting Invitation) » Biomarkers Audit Results from June 2025, Preventative Services_Codes 99381 and 99387 (New Patients)_June 2025, and Preventative Services_Codes 99391 to 99397 (Established Patients)_June 2025 demonstrate that the MCP is actively monitoring biomarker testing and preventative services are not subject to prior authorization requirements. (1.2.1_Biomarkers Audit Results_June 2025, 1.2.1_Preventative Services_Codes 99381 and 99387 (New Patients)_June 2025, 1.2.1_Preventative Services_Codes 99391 to 99397 (Established Patients)_June 2025) **The corrective action for finding 1.2.1 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
1.2.2 Notice of Adverse Benefit Determinations The Plan did not send NOAs for adverse benefit determinations within the required timeframes.	1. **Revise desk-level procedures and workflows** (On Track) 2. **Provide structured training and job aids for nurses** (On Track) 3. **Continuous Monitoring** a. Ongoing system audits to verify role-based access b. Quarterly audits to ensure proper NOA delay issuance c. Supervisors to monitor nurse activity using existing reports. d. Version-controlled templates to maintain consistency (On Track)		1. 05/30/2025 (Short-Term) 2. 05/30/2025 (Short-Term) 3. 06/30/2025 (Short-Term)	The following documentation supports the MCP's efforts to correct this finding. **POLICIES AND PROCEDURES** » UM01 Authorization and Referral Review was revised to require prior authorization decisions and notifications timeframes to adhered to. (1.2.2_UM01 Authorization and Referral Review – Clean) » Administrative Deferral Process demonstrates the MCP has a process in place for processing authorizations that require LOAs. DHCS provided technical assistance on the appropriate use of Delay NOAs. (1.2.2_Administrative Deferral Process 8.27.25) **TRAINING** » Adverse Benefit Determination Training demonstrates the MCP has trained appropriate staff on turn around times and NOA timeframe requirements. Attendance reports were provided. (FINAL_Adverse Benefit Determination Training 2025.pptx, Pharmacy Training Slides_Final_Adverse Benefit Determination Training 2025_Pharmacy.pptx, Adverse Benefit Determination Training 2025_CM_Updated to Dual Branding_th.pptx) **MONITORING**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				» UM Quality Audit Tool is used to monitor compliance with NOA timeframe requirements (1.2.3_UM Audit Tool Column AU and AV) **The corrective action for finding 1.2.2 is accepted.**
1.2.3 Member Notice of Action Templates The Plan did not use the appropriate NOA template to inform members of PA denials.	1. **Revise Policy, UM07 Notice of Action for Delayed, Denied, Modified, or Terminated Services** (On Track) 2. **Train all staff responsible for managing letter templates in the system on the QA Process** (On Track) 3. **Internal quarterly audit includes validation of the appropriate letter** (Completed)		1. 06/15/2025 (Short-Term) 2. 07/15/2025 (Short-Term) 3. Initiated – (Short-Term)	The following documentation supports the MCP's efforts to correct this finding. **POLICIES AND PROCEDURES** » Policy UM07 Notice of Action for Delayed, Denied, Modified, or Terminated Services was revised to include quality performance measuring, where 1. On a quarterly basis, using the NCQA Audit tool, five (5) randomly selected cases with associated letters from each utilization staff member are audited for compliance. The audit includes standard and documentation timeliness, as well as clear and concise language within the NOA. (1.2.3_UM07 Notice of Action for Delayed, Denied, Modified, or Terminated Services For DHCS July Update) **TRAINING** » Prior Authorization Training on September 17, 2025, demonstrates the MCP trained appropriate staff on the watermark and footers on the NOAs that are used to identify the NOA type. (1.2.3_NOA Watermark Staff Training 2025) **MONITORING**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				» UM Quality Audit Tool was updated to include a check for the correct NOA template. Audit began July 1, 2025. (1.2.3_UM Audit Tool Column CK) **The corrective action for finding 1.2.3 is accepted.**
1.3.1 Criteria for Pharmacy Coverage Services The Plan did not comply with all applicable provisions of the Medi-Cal Provider Manual in decision making for coverage of pharmacy services.	**1. Revise Policy, PH05 Prior Authorizations, to include:** a. Define that when medical necessity criteria is not present in Health Plan Coverage Policies, MCG, and the Medi-Cal Provider Manual, then Health Plan reviewers will use Health Plan's General Utilization Management Criteria to determine the medical necessity of the request. (Completed - 08/30/2024) b. Clearly state that the Medi-Cal Provider Manual must be the primary reference for benefit coverage determinations. If the primary (P&T Coverage Policies) or secondary review criteria [Milliman Care Guidelines – (MCG)] directs the decision towards an adverse determination, the Medi-Cal Provider	1. 1.3.1_A. PH05 Prior Authorizations 2. 1.3.1_B. Review of PH05 Updates 3. 1.3.1_C. Internal Weekly Audit Fields	1. 8/30/2024 and 5/2/2025 (Short-Term) 2. 7/31/2025 (Short-Term) 3. 4/21/2025 (Short-Term)	The following documentation supports the MCP's efforts to correct this finding. **POLICIES AND PROCEDURES** » Updated P&P, "PH05: Prior Authorizations" (05/02/25) which has been updated to include the Medi-Cal Provider Manual as a source of criteria. **TRAINING** » Training, "Review of PH 05 10/24 Updates" (10/23/24 and 1028/24) demonstrates the MCP trained all affected pharmacy staff on the updated Policy, PH05 Prior Authorization. » Training, "Review of PH 05 05/25 Updates" (06/25) demonstrates the MCP trained all pharmacy staff on the updated Policy, PH05 Prior Authorization. Attestations included. » Meeting, "Pharmacy and Therapeutics Committee Meeting" (06/10/25) evidence showed a discussion occurred regarding the Policy and Procedure review of PH 05 Prior Authorization. **MONITORING AND OVERSIGHT**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	Manual will be reviewed for the medical necessity criteria related to the request. If the Medi-Cal provider manual has medical necessity criteria for the requested drug it will be utilized to make the final determination of medical necessity. (Completed - 05/02/2025) 2. **Train all affected staff (Pharmacy) on the revised criteria hierarchy and policy updates.** a. Reviewed updated Policy, PH05 Prior Authorization, with all pharmacy staff in October 2024. (Completed) b. The most recent updates made to the PH05 Prior Authorization on 05/02/2025, will be reviewed at the June 2025 P&T meeting. All pharmacy staff are required to review the updates by July 2025. (On Track)			» Desk Level Procedure, "Weekly Pharmacy Prior Authorization Audit" (05/01/25) which outlines the Pharmacy Department's weekly pharmacy prior authorization audit process. These audits verify that documentation meets regulatory and organizational standards. » Policy and Procedure, CMP13, "Internal and External Audits" (12/22/23) which outlines the Compliance Department's annual audit process. » Audit, "Pharmacy Audit" (04/25-06/25) demonstrates the MCP is self-monitoring on a weekly basis to make certain that the Provider Manual is being referenced in decision making for coverage of pharmacy services. **The corrective action for finding 1.3.1 is accepted.**

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	3. **Incorporate verification of adherence to the PH05 review hierarchy into internal weekly audits of medical necessity determinations.** ◦ This process will enable prompt feedback to team members who may have overlooked referencing the Medi-Cal Provider Manual, as required by the hierarchy outlined in PH05. (Completed)			

3. Access and Availability of Care

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
3.6.1 Prior Authorization Requirements for Family Planning Services The Plan incorrectly applied PA requirements to family planning services.	1. Revise policies and procedures that address benefit end to end implementation. ◦ This process improvement is meant to align with the updates that are occurring in our core billing system. (On Track) **2. Interdepartmental Collaboration and Training:** ◦ Configuration team is currently reviewing all Medi-Cal Benefits in the core claim billing system with Medical Management team for proper prior authorization requirements. Review of benefits in core billing systems began 04/23/2025. We are updating our systems accordingly with proper prior authorization requirements. (On Track)		1. 06/30/2025 (Short-Term) 2. Initiated 04/23/2025 (Short-Term) 3. a. 06/01/2025 (Short-Term) Initiated – 05/02/2025 (Short-Term)	The following documentation supports the MCP's efforts to correct this finding. **POLICIES AND PROCEDURES** » P&P, UM01, "Authorization and Referral Review" (01/2024) demonstrates the MCP revised UM01 to state, Pre-service authorization is not required for family planning services. » DLP, "Benefit Process" (06/09/25), which outlines the MCP's audit process. Audits will be conducted every six months on new, updated, and termed benefits. **IMPLEMENTATION** » Workflow, "DLP Flow Chart Benefit Process" (DRAFT) demonstrates that the MCP provides an overview of the process they follow when adding, updating, or removing a benefit. This flowchart offers a simplified view of the steps taken to ensure that all business leaders are informed. **MONITORING** » Narrative, "Attestation, Core Billing System" (08/28/25). The MCP has completed a comprehensive review of all benefits requiring prior authorization and has also received approval from the Medical Director. The MCP has validated that all benefits requiring prior authorization are correctly identified and documented. These

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				requirements will be fully incorporated into the configuration of the new Claims Management System, scheduled for implementation in mid-September 2025. » Testing, "Targeted Testing" (09/25) demonstrates that the MCP has successfully completed the targeted testing for CA Biomarker, Family Planning, and Sensitive Services Screening claims. The system configuration updates have been accurately implemented. Please refer to documents 3.6.1 2107200 Cancer Service Codes and 3.6.1 2107200 Preventive Service Codes. The MCP has initiated ongoing monitoring to ensure that it maintains accuracy in claims adjudication, thereby safeguarding the integrity of its system. **TRAINING** » Meeting, "BRAC Weekly Meeting Invitation" (05/25) demonstrates the MCP has initiated a weekly meeting series to address benefit updates. Claims, configuration, and Benefits Administration are all part of these meetings. The meeting series began on 5/5/25. » Meeting, "PowerPoint/BRAC Meeting Slide Deck" (09/08/25) demonstrates that the MCP covered several key points, including the crucial clarification that prior authorizations are not required for Family Planning Services. The MCP wanted to ensure that everyone is clear on this, as it will impact their processes moving forward. Additionally, the MCP identified that authorizations had been incorrectly applied in the past. The MCP also outlined the corrective

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				actions implemented through the QNXT 2.0 project to address these issues. These steps will significantly improve the MCP's process moving forward. Attestations included. » Meeting, "BRAC Process Improvement Project" (07/08/25), demonstrates that the MCP has trained staff from claims, configuration, and benefits administration during the weekly BRAC meetings. **The corrective action plan for finding 3.6.1 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: _____

Title: _____

Signed by: Signature on File

Date: _____