CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

December 29, 2023

Sunny Cooper, Chief Compliance Officer
Health Plan of San Joaquin
7751 S. Manthey Rd.
French Camp, CA 95231

RE: Department of Health Care Services Medical Audit

Dear Mr. Cooper:

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 10, 2022 through October 21, 2022. The audit covered the period of July 1, 2021 through September 30, 2022.

The items were evaluated and DHCS accepts 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
Managed Care Quality and Monitoring Division
Department of Health Care Services Department of Health Care Services

Enclosures: Attachment A (CAP Response Form)

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

Christina Viernes, Lead Analyst
Audit Monitoring Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

Travis Romo, Contract Manager
Medi-Cal Managed Care Division
Department of Health Care Services

ATTACHMENT A
Corrective Action Plan Response Form

Plan: Health Plan of San Joaquin **Review Period: 07/01/21 – 09/30/22**

Audit Type: Medical Audit and State Supported Services **On-site Review: 10/10/22 – 10/21/22**

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

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. The MCP shall directly address each deficiency component by completing the following columns provided for MCP response: 1. Finding Number and Summary, 2. Action Taken, 3. Implementation Documentation, and 4. Completion/Expected Completion Date. The MCP will be required to include project timeline with milestones in a separate document for each finding. Supporting documentation should accompany each Action Taken. If supporting documentation is missing, the MCP submission will not be accepted. For policies and other documentation that have been revised, please highlight the new relevant text, and include additional detail such as title of the document, page number, revision date, etc. in the column "Supporting Documentation" to assist DHCS in identifying any updates that were made by the plan. For deficiencies that require short-term corrective action, implementation should be completed within 30 calendar days. For deficiencies that may be reasonably determined to require long-term corrective action for a period longer than 30 days to completely remedy or operationalize, the MCP is to indicate that it has initiated remedial action and is on the way towards achieving an acceptable level of compliance. In those instances, the MCP will be required in addition to the above steps, to include the date when full compliance will be achieved. Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval, as applicable in accordance with existing requirements.

Please note, DHCS expects the plan to take swift action to implement improvement interventions as proposed in the CAP, therefore DHCS encourages all remediation efforts to be in place no later than month 6 of the CAP, unless prior approval for an extended implementation effort is granted by DHCS.

DHCS will maintain close communication with the MCP throughout the CAP process and provide technical assistance to ensure the MCP provides sufficient documentation to correct deficiencies. Depending on the volume and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates, as applicable.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
1. Utilization Management				
1.2.1 Prior Authorization Medical Coverage Criteria The Plan did not use the appropriate coverage criteria to deny medical service requests.	1. Revised P&P UM06 Medical Review Criteria 2. Train HPSJ UM Staff, Medical Directors, and Peer Reviewers 3. Revise IRR Desk Level Procedure (DLP) 4. Train UM Staff, Medical Directors, & Peer Reviewers on appropriate criteria for Medical Necessity Determinations 5. Update Audit Tools	• HPSJ2022_CAP_07 (CAP Form) 1. Attachment A: Communication to UM Staff Cancer Biomarker Testing 08/12/2022 2. Attachment B: UM Staff Meeting Minutes 10/12/2022 3. Attachment C1: EPSDT Training 11/16/2022 4. Attachment C2: Meeting Attendance Report (EPSDT Training) 11/16/2022 5. Attachment D1: Training Cancer Markers 02/22/2023 6. Attachment D2: Biomarker Training Roster 02/23/2023	1. Long Term 09/01/2023 2. Long Term 08/2022 to 09/30/2023 3. Long Term 08/01/2023 4. Short Term 07/15/2023 5. Long Term 09/01/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policy UM-6 Medical Review Criteria was updated to confirm correct criteria is used. External physician members of the committee participate in the annual review of criteria, as well as criteria adoption. Criteria are utilized to determine medical necessity and clinical appropriateness of medical and behavioral healthcare and pharmaceutical services requiring approval. (CAP 1.2. 1. a UM06_Medical Review Criteria_Combined.docx) • IRR DLP was updated to use case based on actual referrals. (CAP 1.2.1 3 Inter-Rater Reliability DLP.doc) • Benefit Training Process DLP demonstrates the MCP has a process in place to notify decision makers of new benefits, code changes, medical necessity criteria updates and other information impacting benefits, services, or medical necessity criteria, training in new benefits guidance and the performing of focused audits for the initial 3-month period following staff

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				training/implementation. (1.2.1_Leadership DLP_Benefit Training_Final.docx) **TRAINING** • Email dated 10/6/22 demonstrates MCP staff were informed of APL 22-010 cancer biomarker testing requirements. (HPSJ2022_CAP_1.2.1_Attachment-A) • Staff meeting agenda from 10/12/23 demonstrates the MCP's staff on the changing biomarker testing process due to the requirements of APL 22-010. (HPSJ2022_CAP_1.2.1_Attachment-B) • EPSDT Training and sign-in sheet demonstrates the MCP has trained its staff on EPSDT medical necessity requirements. (HPSJ2022_CAP_1.2.1_Attachment-C1 & HPSJ2022_CAP_1.2.1_Attachment-C2) • Prior Auth Nurse Training from 2/22/23 demonstrates the MCP has trained its staff on medical necessity requirements for various cancer markers. (HPSJ2022_CAP_1.2.1_Attachment-D1 & HPSJ2022_CAP_1.2.1_Attachment-D2)

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				MONITORING AND OVERSIGHT • Medical Management Desk Level Procedure demonstrates the MCP has a process in place to audit decision makers on a quarterly basis. Audit will consist of randomized selection of three denials, one modification, and one approval per reviewer. Focus audits will be performed in a number of circumstances until compliance is achieved. Including New or updated medical necessity criteria or guidelines. (1.2.1_Internal UM Audit DLP.docx) **The corrective action plan for finding 1.2.1 is accepted.**
2. Case Management and Coordination of Care				
2.1.1 Anticipatory Guidance for Lead Exposure and Lead Poisoning The Plan did not ensure the provision of oral or written blood lead anticipatory guidance to the parent(s) or guardian(s) of a child	1. Revised P&P QM66 Blood Lead Screening of Young Children 2. Updated Audit Tool 3. Send Provider Alert for re-education 4. Add Blood Lead Gaps and Guidance Document to Quarterly Provider Communication	• HPSJ2022_CAP_2.1.1_and _2.1.2_0Narrative 1. Attachment A: P&P QM66 Lead Screening in Children 2. Attachment B: HPSJ Lead Screen Data Collection Review Audit Tool 3. Attachment C: Provider Alert for Lead Screening	1. Long Term 10/2022 2. Long Term 06/2023 3. Short Term 07/10/2023 4. Short Term 07/24/23	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated P&P, "QM 66: Blood Lead Screening of Young Children" (May 2023) states that all instances of oral or written anticipatory guidance provided to caregivers must be documented. The provider must document the reason for not obtaining a signed statement of voluntary refusal in the child's medical record. The MCP will

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member at each PHA starting at six months of age and continuing until 72 months. 2.1.2 Provision of Blood Lead Screening of Young Children The Plan did not ensure the provision of a BLS tests to members at 12 months to 72 months of age.		4. Attachment D: Lead Screening Documentation Guide		perform an annual audit to determine whether anticipatory guidance, blood lead testing, testing results and/or caregiver refusal are documented. (Section III, A.4.iii). **TRAINING** • A reminder Provider Alert will be sent to all primary care providers by 07/10/2023 for re-education on the required blood lead screenings and all required documentation including anticipatory guidance. (Provider Alert). • During the quarterly communication to all Primary Care Providers regarding blood lead gaps, a guidance document for appropriate documentation of anticipatory guidance, blood test and or parent/caregiver refusals in medical records will be distributed by 07/24/23. (Screening Documentation Guide). • PowerPoint Presentation, “Lead Screening Requirements” to demonstrate that the MCP developed a training material to re-educate providers who are found to be out of compliance. (File name “Lead Screening and Poison Prevention Training”). **MONITORING AND OVERSIGHT**

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				• Template, “Corrective Action Plan” to demonstrate that the MCP will implement a corrective action process with all Non-Compliant Providers which are identified through the Annual Survey, data reports, and medical record review. Notifications of non-compliance will be sent to Providers within 60 days of audit completion. Provider remediation activities are to be returned to the plan within 30 days of notification. The CAPs will be presented in QMUM meetings for further feedback. (HPSJ Blood Lead Screening Corrective Action Plan Template). • Audit Report, “HPSJ Lead Screening Annual Report: Compliance, Monitoring, and Improvement – Measurement Year 2022” (July 2023) to demonstrate that the MCP has implemented a monitoring process to track the provision of oral or written blood lead anticipatory guidance to the parent(s) or guardian(s) of a child member at each PHA starting at six months of age and continuing until 72 months. The MCP annually monitors compliance with lead screening and documentation of anticipatory guidance on the dangers of lead poisoning and caregiver refusals. The MCP also quarterly monitors members who have not received lead

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				screening up to age 6 and sends quarterly reports to all contracted primary care practitioners. The MCP has planned several interventions including funding point of care testing machines, implementing corrective action plans for non-compliant physicians, and additional physician education for documentation. (HPSJ 2022 CAP Update 2.1.1 and 2.1.2 Lead Screening MY 2022 FINAL). **The corrective action plan for finding 2.1.1 is accepted.**
3. Access and Availability of Care				
3.1.1 Compliance with Appointment Wait Time Standards The Plan did not ensure that corrective actions were implemented for providers who did not comply with appointment wait time standards.	1. Revised P&P PRO28 Access and Availability Standards and Monitoring 2. Created Desk Level Procedure (DLP) for monitoring Providers	• HPSJ2022_CAP_3.1.1_3.1.2_3.1.3_0Narrative 1. Attachment A: PRO28_Access and Availability Standards and Monitoring 2. Attachment B: Desk Level Procedure Timely Access Monitoring	1. Long Term 12/01/2022 2. Long Term 08/01/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Revised P&Ps "Policy PRO28 Access and Availability Standards and Monitoring" [HPSJ2022_CAP_3.1.1_3.1.2_3.1.3_Attachment-A] revised in December 2022 which now includes methods of monitoring providers for timely access standards; requirements for monitoring providers for timely telephone answer/return times; requirements for monitoring

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3.1.2 Telephone Wait Times The Plan did not monitor the wait times for providers to answer and return calls to members.				providers' in-office wait times and includes a procedure for notification of deficiencies with access standards to providers, such as, education, re-survey, and tracking which will result in corrective actions. **MONITORING AND OVERSIGHT** • A Desk Level Procedure (DLP) for monitoring providers was created and implemented on 8/1/2023. DLP includes monitoring of providers by surveys, grievances, etc., escalation steps to Plan QOC for review and action. [HPSJ2022_CAP_3.1.1_3.1.2_3.1.3_Attachment -B] • The Plan provided multiple sample letters as evidence which demonstrates implementation of DLPs created on 8/1/2023. The Plan has demonstrated that corrective actions were implemented for non-compliant providers. **The corrective action plan for findings 3.1.1, 3.1.2 and 3.1.3 has been accepted.**
3.1.3 Provider Office Wait Times The Plan did not have a policy and procedure to monitor providers' compliance with wait times in the providers' offices for scheduled appointments.				

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
3.2.1 Physician Certification Statement The Plan did not ensure the use of a DHCS-approved PCS form, complete with required information, to determine the appropriate level of service for Medi-Cal members.	1. Revised P&P UM55 NEMT 2. Update Desk Level Procedures (DLP's) 3. Train HPSJ UM staff 4. Train community providers 5. Routine monitoring/Audit of NEMT files	• HPSJ2022_CAP_07 1. Attachment A: UM55 Emergency and Non-Emergency Medical Transportation 2. Attachment B: 5.2023 Transportation Job Aid for PHN 3. Attachment C: 5.23.23 Transportation Job Aid for RN 4. Attachment D: 8.02.22 Clinical Ops meeting 5. Attachment E: 10.06.22 Updated HPSJ_NEMT-PCS-Form Fillable 6. Attachment F: 11.14.22 PCS Assessment - Attendance report 11-14-22 7. Attachment G: 1.27.23 PCS Form Changes notification to UM Staff	1. Long Term 11/2022 to 08/2023. 2. Long Term 10/2022 to 05/2023. 3. Long Term 08/02/2023 – 07/31/2023 4. Long Term 5. Long Term 08/01/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Plan policy "P&P UM55 NEMT" was updated to demonstrate compliance with requirements regarding the DHCS-approved PCS form being utilized & completed to be able to determine the appropriate level of service for Medi-Cal members. "The treating provider shall submit a request for authorization of NEMT for approval prior to delivering services." (III. Procedure, A. 1. a-d, page 5) • Plan procedures "RN_Transportation Job Aid" & "Job_Aid_PHN" demonstrates the process for when a PCS form does not meet the requirements & is incomplete, the Plan will defer the non-urgent request until the DHCS-approved PCS form is completed. The Plan provides provider education to assist in the completion of the PCS form. (Process, 2. B & C, page 2 & 4) **MONITORING AND OVERSIGHT** • The Plan's tracking mechanism, "PCS Audit Tool" demonstrates the Plan's monitoring for the compliance of completed PCS forms, verifying

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		8. Attachment H: 1.25.23 Updated Physician Certification Form (PCS) – Request for Transportation for Non-Emergency Medical Transportation (NEMT) 9. Attachment I: 3.22.23 REMINDER – Updated Physician Certification Form (PCS) – Request for Transportation for Non-Emergency Medical Transportation (NEMT) 10. Attachment J: 6.26.23 Provider Fax Blast re: completion of PCS Form 11. Attachment K: 10.07.22 Updated HPSJ_NEMT-PCS-Form Fillable 12. Attachment L1: 5.10.23 NEMT Update Look N Learn		the components required for a completed PCS form. (3.2.1_PCS Audit Tool) • Plan policy "P&P UM55 NEMT" reflects the monitoring process, which is completed quarterly through report monitoring & ad hoc audits for all elements. (III. Procedure, H., page 7) **TRAINING** • The "Training Materials" demonstrate the Plan's training processes. The training emphasized the requirements for the PCS form to be considered complete: o NEMT training (8/2/23) o Quarterly All Team meeting (08/16/2023) **The corrective action plan for finding 3.2.1 is accepted.**

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		13. Attachment L2: 5.10.23 Look and Learn Attendance 14. Supplemental Documentation Deficiency 7 re: PCS Forms		
3.2.2 Medi-Cal Enrollment of NEMT Providers The Plan did not ensure that its NEMT providers are enrolled in the Medi-Cal program.	1. Provider Contracting verifies all potential new provider enrollment in Medi-Cal FFS. (Process already in place). 2. Implement new process with IT Department to automatically verify enrollment status of contracted providers on a monthly basis.	1. HPSJ2022_CAP_3.2.2_0Narrative 2. Attachment A: P&P CONT01 3. Attachment B: Response to Verification Study results 4. Attachment C: Evidence of verification of enrollment of the providers listed in the Study.	1. Long Term 2. Long Term 08/30/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • The Plan verifies the enrollment status of all contracted providers by cross checking with the Medi-Cal FFS roster. (MCL FFS Validation_08.28.23, page 1) • Revised policy, "CONT13_Contract Terminations" indicates the Plan will terminate providers' contract if they fail to meet contractual obligations. (II. Policy, 2., page 2) **MONITORING AND OVERSIGHT** • 3.2.2_Transportation Roster. The Plan tracks all providers with the Transportation Roster. All providers are enrolled, pending within 120-day timeframe or have been terminated. The roster was submitted & approved by the MCQMD SME

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				for transportation. (Also see 09-19-23 Transpor Roster Approval) • MCL FFS Validation_08.28.23.The Plan verifies the enrollment status of all contracted providers on a monthly basis cross checking with the Medi-Cal FFS roster. (page 1) • CONT13_Contract Terminations. If a provider is identified as non-compliant, the Plan will initiate the termination & upon approval of termination the Network manager will notify compliance, claims, credentialing, customer service, medical management, provider data maintenance & provider services of the termination. (III. Procedure, 2.a., page 3) o Policy indicates the Plan will terminate providers' contract if they fail to meet contractual obligations. (II. Policy, 2., page 2) **The corrective action for finding 3.2.2 is accepted.**
4. Member Rights				

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
4.1.1 Grievance Resolution The Plan did not ensure full grievance resolution prior to sending resolution letters.	1. Revised P&P GRV02 Grievance Procedures 2. Updated Grievance Process Document 3. Provide additional Staff Training 4. Created a new Workflow Process 5. Implement Quarterly Audits 6. Hire new staff	• HPSJ2022_CAP_4.1.1_0Narrative 1. Attachment A: P&P GRV02 Grievance Procedure 2. Attachment B: G/A Tag Up Agenda 05/23/2023. 3. Attachment C: Training Grievance Process 4. Attachment D: DLP Grievance Process Provider No Response 5. Attachment E: Grievance Audit Template	1. Long Term 06/01//2023 2. Long Term 06/01/2023 3. Long Term 05/23/2023 4. Long Term 07/01/2023 5. Long Term 10/01/2023 6. Long Term 10/01/2022	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policy GRV02 Grievance Procedures was updated to include the requirement that grievances are completely and fully investigated and resolved prior to sending the resolution letter. (Attachment A_GRV02 GrievanceProcedures • New Provider Response Workflow was developed to address provider non-responses to grievance inquiries. The workflow contains escalation procedures to obtain a response. (Attachment D_DLP_Grievances_Process_Provider_No_Response) **TRAINING** • Training and agenda from 5/23/23 demonstrates MCP was trained on the requirement to fully resolve grievances prior to sending resolution letters and notifying members in writing when grievances are not resolved within 30 days. (Attachment B_G&A_TagUpAgenda_05.23.23)

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				MONITORING AND OVERSIGHT • Grievance audit template includes a field for verifying all issues of the grievance are fully investigated and resolved. (Attachment E_Grievance Audit Template) • Grievance Audit October 2023 demonstrates the MCP is actively auditing grievances to verify grievances are fully resolved prior issuing resolution letters. (Grievance audit Oct.2023) **The corrective action plan for finding 4.1.1 is accepted.**

Submitted by Plan: Tamara Hayes **Date: 12/18/2023**
Title: Director of Compliance