DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

December 5, 2024

Tamara Hayes, Director of Compliance
Health Plan of San Joaquin
7751 S. Manthey Rd.
French Camp, CA 95231

*Via E-mail*

RE: Department of Health Care Services Medical Audit

Dear Ms. Hayes:

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 30, 2023 through November 10, 2023. The audit covered the period from October 1, 2022, through July 31, 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: Stacy Nguyen, Chief *Via E-mail*
Managed Care Monitoring Branch
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

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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
**Audit Type:** Medical Audit

**Review Period: 10/01/2022 – 07/31/2023**
**On-site Review: 10/30/2023 – 11/10/2023**

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 |
|---|---|---|---|---|
| **1.5.1 Behavioral Health Program Oversight**<br><br>The Plan did not implement its policies to include a behavioral health practitioner in its QIHEC for oversight of the delegated behavioral health program. | 1. In order to assist with addressing the shortage of Behavioral Health Practitioners who are available to lighten the patient load, the Health Plan has invested in grants that will assist with recruitment and retention of practitioners in the San Joaquin Valley, scholarships for individuals who are pursing health careers, and hiring more social workers to build trust with members who are facing challenges that may impact their sense of well- being.<br><br>2. Finally, the Health Plan has recruited the most senior Behavioral Health Program Administrator, the Chief of Behavioral Health, from the largest partnering FQHC to serve on the | CAP Form_1.5.1 Behavioral Health Program Oversight<br><br>Attachment A_QIHEC Meeting Minutes_January and March 2024 | Short-Term:<br><br>05/15/2024<br><br>(On Track) | The following documentation supports the MCP's efforts to correct this finding:<br><br>**MONITORING AND OVERSIGHT**<br><br>• QIHEC Meeting Minutes_January and March 2024 and BH Program Oversight Attendance QIHEC from 5/15/24 demonstrate the MCP has recruited a behavioral health practitioner in its QIHEC for oversight as a voting member. (Attachment A_QIHEC Meeting Minutes_January and March 2024, 1.5.1_BH Program Oversight_Attendance_QIHEC_2024.05.15)<br><br>**The corrective action plan for finding 1.5.1 is accepted.** |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date * (*Short-Term, Long-Term) | DHCS Comments |
|---|---|---|---|---|
| | Quality and Equity Oversight Committee and provide oversight of the Delegated Behavioral Health Quality Program.<br><br>3. The Health Plan has persisted and succeeded in recruiting the Medical Director from the San Joaquin County Behavioral Health Program to attend the QIHEC meetings and as of the May QIHEC, she will be a voting member of the committee. | | | |
| **1.5.2 Integration of UM Reports**<br><br>The Plan did not ensure its delegate generated accurate integrated reports in the review of | 1. Issue corrective action plan request to delegate for remedying utilization management reporting issues.<br><br>2. Develop desk level procedure and tool for ongoing evaluation of delegate's utilization management | o CAP Form_1.5.2 Integration_UM_Reports<br><br>o Attachment A_All UM Evaluation Tool_2023<br><br>o Attachment B_AO0013_DLP_Carelon_UM_Activity_Report Rev 2023-12-15 | 3/28/2024<br><br>12/15/2023 | The following documentation supports the MCP's efforts to correct this finding:<br><br>**POLICIES AND PROCEDURES**<br><br>• Carelon UM Activity Report was created by the MCP for the evaluation of the delegates utilization management reports for number and types of appeals, denials, deferrals, and modifications. (Attachment B_AO0013_DLP_Carelon_UM_Activity_Report Rev 2023-12-15) |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date * (*Short-Term, Long-Term) | DHCS Comments |
|---|---|---|---|---|
| the number and types of appeals, denials, deferrals, and modifications for the Plan's QI/UM evaluation. | reports, including number and types of appeals, denials, deferrals, and modifications.<br><br>3. Develop PowerPoint template exhibiting results of evaluation.<br><br>Present results of evaluation to Audits and Oversight Committee quarterly. | o Attachment C_AOC Meeting Packet<br><br>o Attachment D_Carelon_2023_All_UM_Activity_Report_CAP_Form | 3/28/2024<br><br>3/28/2024 | **MONITORING AND OVERSIGHT**<br><br>• Carelon Monthly All UM Activity Report Evaluation Tool demonstrates the MCP is continuously monitoring its delegate for accuracy of its reports.<br><br>• Corrective Action Plan for Delegate UM Activity Report request was issued by the MCP for the delegate to correct it UM reporting issues. The CAP request instructs the delegate to address the issue of missing key data and the misclassification of routine services as concurrent review. (Attachment D_Carelon_2023_All_UM_Activity_Report_CAP_Form)<br><br>• Delegation Oversight Committee 12/5/23 & 2/6/24 Meeting Packet demonstrates the MCP is reporting its oversight results of it delegate to Audits and Oversight Committee. (Attachment C_AOC Meeting Packet)<br><br>**The corrective action plan for finding 1.5.2 is accepted.** |
| **1.5.3 Collection and Review of** | In our remediation plan, we've outlined a series of steps aimed at addressing the identified | CAP Form_1.5.3 Delegate Ownership and Control | | 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 |
|---|---|---|---|---|
| **Delegate Ownership and Control**<br><br>The Plan did not collect and review ownership and control disclosures for its delegate. | issues.<br><br>1. Developed procedure to provide clear guidance on the collection and review of ownership and control disclosures for delegates and subcontractors.<br><br>2. Ensure that all relevant staff members understand and adhere to these updated guidelines through comprehensive training sessions.<br><br>3. Non Medi-Cal Enrolled Providers and Delegated Providers are required to submit a DHCS approved Ownership Disclosure form, which is collected with the Provider contract. | Attachment A_DLP_DRAFT_Disclosure_of_Ownership_v1<br><br>Attachment B_DLP-RM005a_Prov Verification Training for BOs<br><br>Attachment C_DLP-RM005b_Prov<br><br>Verification Steps | 5/10/2024 | **POLICIES AND PROCEDURES**<br><br>• Plan revised DTP FIN50.PROC Third Parties Disclosure of Ownership and Controls (4/24). Policy compliant with APL 23-006, including requirement to report subcontractor non-compliance to MCOD within 10 business days of discovery. Additionally, Plan updated policy to include address for each person or each managing employee as required by 455.104.<br><br>**TRAINING**<br><br>• Staff training was held in June 2024. The Plan provided evidence of training, 1.5.3_Procurement_Training, which includes a list of attendees, training materials, and a DLP. Relevant information was highlighted in yellow.<br><br>**MONITORING AND OVERSIGHT**<br><br>• Plan is establishing monitoring mechanism to track the collection and review of ownership and disclosure requirements on an annual basis. Communication channels between departments is being enhanced to facilitate timely and accurate exchange of information. Periodic audits are |

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|---|---|---|---|---|
| | 4. The Provider Services Department notifies Provider Contracting when a contracted Provider changes their TIN, which occurs when there is an ownership change.<br><br>5. Stipulate in the procurement process that vendors must notify the Health Plan either before ownership transfer or promptly thereafter.<br><br>6. Additionally, we'll establish a monitoring mechanism to track the collection and review of ownership documentation on an annual basis, enhancing accountability and oversight within the organization. | | | being proposed to verify compliance with Plan policies and regulatory requirements.<br><br>**TECHINCAL ASSISTANCE**<br><br>• Plan was advised to continue to demonstrate subcontractors accurately provide all required information in their disclosures. The Plan must review all disclosure forms to identify potential conflicts of interests and make subcontractor ownership and control disclosures available upon request, as information is subject to audit.<br><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 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 |

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|---|---|---|---|---|
| | Communication channels between departments involved in the collection and review process will be strengthened to facilitate timely and accurate exchange of information. | | | condition for receiving Medicaid dollars and failure to comply may lead to sanctions.<br><br>• Failure to collect and review required disclosure information from subcontractors violates federal regulation, the managed care contract, and All Plan Letter 23-006. DHCS may impose sanctions against MCPs for this non-compliance, including the imposition of a corrective action plan, monetary sanctions, temporary suspension orders, and contract termination (42 CFR § 700; 42 CFR § 438.702(b); Welfare and Institutions Code § 14197.7(a); also see DHCS MCP Contract and APL 23-012).<br><br>• DHCS Guidance: Ownership and Disclosure Requirements for additional information, including regulatory and contractual authority, monitoring requirements, the imposition of corrective action, and other enforcement actions.<br><br>**The corrective action plan for finding 1.5.3 is accepted.** |

## 2. Case Management and Coordination of Care

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date * (*Short-Term, Long-Term) | DHCS Comments |
|---|---|---|---|---|
| **2.1.1 Complex Care Management Plans**<br><br>The Plan did not complete CMPs for all members receiving CCM. | 1. Enhance data sources that inform the risk stratification to ensure more accurate identification of high-risk members. The following data sources will be included in the risk stratification:<br><br>Near real-time ADT information from the local HIE (9/23)<br>b) Referrals (8/23)<br>c) HIF-MET data (10/23)<br>d) HRA data (8/23)<br>e) All-Payer Claims Database (APCD) from DHCS is in the process of being incorporated into the risk stratification.<br>f) Assessment information from providers (future state)<br><br>2. Update risk stratification desk | CAP Form_2.1.1 CCM Plans_5.2.24<br><br>Attachment A_Case Management Program Description<br><br>Attachment B_Risk Stratification Reference 2022<br><br>Attachment C_Risk Stratification Reference 2023<br><br>Attachment D_CM_Audit_Tool | Moderate-Term:<br><br>09/30/2024<br><br>(On Track – The Health Plan has initiated remedial action and is on the way towards achieving an acceptable level of compliance.) | The following documentation supports the MCP's efforts to correct this finding:<br><br>**POLICIES AND PROCEDURES**<br><br>• Updated P&P, CM 71, "Complex Case Management" (12/10/23) demonstrates the MCP made an update to include the components of a comprehensive assessment, components of a comprehensive individualized care plan, and provision of the components for all members receiving CCM.<br><br>• Reference, "Risk Stratification Desk Level Reference" (10/2023) demonstrates the Plan performs monthly risk stratification and member segmentation into intervention groups based on the risk score. The algorithm identifies members as high, medium, or low risk for the appropriate intensity of care coordination intervention. (Attachment C_Risk Stratification Reference 2023.doc)<br><br>• Desk Level Procedure, "Risk Stratification Data Pull" (06/07/24) demonstrates the Plan has a descriptive process for identifying member risk levels. (2.1.1_DLP Risk Strat Data Pull.pdf) |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date *<br><br>(*Short-Term, Long-Term) | DHCS Comments |
|---|---|---|---|---|
| | level reference to define what data sources are included in risk stratification of new members.<br><br>Update existing case management policies and procedures to ensure inclusion of Health Plan risk stratification for members. The Health Plan will also review and ensure existing policy language continues to meet regulatory requirements regarding development of CMPs for complex case management (CCM) members.<br><br>4. Conduct re-training of staff on completion of CMP reviews by 6/30/2024.<br><br>5. Continue to conduct case file | | | • Desk Level Procedure, "Medical Management Desk Level Procedure, and Internal CCM Audit" (08/31/23) demonstrates the Plan has a process for their quarterly audits. These quarterly audits will be conducted on active or closed cases per case manager to demonstrate compliance with regulatory requirements. These audits will be conducted one to two weeks following each quarter. The audit results will be communicated quarterly to the respective managers and supervisors.<br><br>• Desk Level Procedure, "Complex Case Management Chart Audit Results" (08/30/24) demonstrates how the MCP will address ongoing non-compliance of scores under 80%.<br><br>• Correction Action Plan (CAP), "CAP, DHCS 2023 Regular Audit" (Date issued 04/09/24 demonstrates the Plan issued a CAP to its Director of Case Management Department. The Case Management Director provided remediation plan/steps to provide an outline of the steps the Department will take to address each issue identified in the root cause analysis and Plan/Steps to avoid reoccurrence of the issue. The remediation plan start date was 08/01/23 and the remediation plan end date is 09/30/24.<br><br>• Program Description, "Complex Case Management Program |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date *<br><br>(*Short-Term, Long-Term) | DHCS Comments |
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| | audits to ensure development of the CMP for CCM members.<br><br>6. Updated Case Management Program Description to include risk stratification methodology. | | | Description" (FY 2022-2023) demonstrates the MCP has included Risk Stratification and Segmentation and referrals to Complex Case Management.<br><br>• Project, "External EMR Access Project" (10/07/24) demonstrates the MCP is developing a process for existing employees or new hires to gain access to medical records whether they are electronic or physical. Implementation date is 12/31/24.<br><br>**MONITORING AND OVERSIGHT**<br><br>• Sample, "Sample Care Plan", (07/01/24) demonstrates the Plan confirms that member files contain evidence of an ICP with primary care physician or family member input. (2.1.1_CM Sample Care Plan)<br><br>• Template Audit Tool, "CM Audit Tool" demonstrates the Plan will conduct quarterly reviews of ongoing management of the following:<br>o Care Plan goals specific to Member's situation and needs (based on the initial assessment).<br>o Care Plan goals have Target and/or Completion Date.<br>o Care Plan goals are prioritized and reflected to Member's preferences.<br>o Barriers are specific to each goal. |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date *<br><br>(*Short-Term, Long-Term) | DHCS Comments |
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| | | | | ○ Copy of Care Plan provided to Provider.<br>○ Documented Progress toward each goal.<br>○ When there is no progress over time, goal(s) are reassessed and modified as appropriate. (2.1.1_Attachment D_CM_Audit_Tool.xlsx)<br><br>• Audit Summary, "CCM File Audit Summary" (05/07/24) demonstrates the Plan selects a randomized selection of three to five files and prioritizing cases that have been completed (e.g., goal met). If there are insufficient cases for one type of outcome, the algorithm will attempt to randomly select the next prioritized type so that each case manager has at least three to five cases selected for the audit. The CCM audit results will entail the following:<br>○ Each case will receive a percentage-based grade.<br>○ Each case manager will be rated based on their average percentage.<br>○ Preliminary findings will be shared and discussed with the respective managers and supervisors.<br>○ Managers and supervisors will have the opportunity to appeal any findings.<br>○ The finalized audit results will be archived and distributed to managers, supervisors, and directors. |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date *<br><br>(*Short-Term, Long-Term) | DHCS Comments |
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| | | | | • Audit Results, "CCM Audit Results" (Q1 – Q3 2024) demonstrates the MCP meets with each Case Manager individually to review the quarterly audit. The Case Management Manager provides feedback regarding the findings and provides coaching and education to support the learning and development of the Case Manager. Audit results from Q1-Q3 average was 83.62% compliant.<br><br>• Review, "Quarterly Review, Referrals from CCM" (Q2 and Q3 2024) demonstrates the MCP conducted quarterly reviews of referrals from CCM. The member's risk score is based on the inclusion of data from DHCS' All Payer Claims Database (APCD) 2024. In Q2, there was a total of 21 referrals from CCM and Q3, a total of 33 referrals from CCM (increased since the inclusion of the ACPD).<br><br>**TRAINING**<br><br>• Staff Training, "CCM Refresher Training" (06/27/24) demonstrates the Plan provided training to Case Management Director, Manager, Supervisor, Lead, and RNs with regard to completion of CMP reviews.<br><br>**The corrective action plan for finding 2.1.1 is accepted.** |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date *<br><br>(*Short-Term, Long-Term) | DHCS Comments |
|---|---|---|---|---|
| **2.1.2**<br>**NCQA Complex Case Management Requirements**<br><br>The Plan did not maintain procedures to ensure a comprehensive assessment of the Members' condition in accordance with NCQA guidelines. | Enhance data sources that inform the risk stratification to ensure more accurate identification of high-risk members. The following data sources will be included in the risk stratification:<br><br>a) Near real-time ADT information from the local HIE (9/23)<br>b) Referrals (8/23)<br>c) HIF-MET data (10/23)<br>d) HRA data (8/23)<br>e) All-Payer Claims Database (APCD) from DHCS is in the process of being incorporated into the risk stratification.<br>f) Assessment information from providers (future state) | CAP Form_2.1.2 NCQA CCM Requirements<br><br>Attachment A_Case Management Program Description<br><br>Attachment B_Risk Stratification Reference 2022<br><br>Attachment C_Risk Stratification Reference 2023<br><br>Attachment D_CM_Audit_Tool | Moderate-Term:<br><br>09/30/2024<br><br>(On Track – The Health Plan has initiated remedial action and is on the way towards achieving an acceptable level of compliance.) | The following documentation supports the MCP's efforts to correct this finding:<br><br>**POLICIES AND PROCEDURES**<br><br>• Desk Level Procedure, "Risk Stratification Data Pull" (06/07/24) demonstrates the Plan has a descriptive process for identifying member risk levels. (2.1.1_DLP Risk Strat Data Pull.pdf)<br><br>• Desk Level Procedure, "Medical Management Desk Level Procedure, and Internal CCM Audit" (08/31/23) demonstrates the Plan has a process for their quarterly audits. These quarterly audits will be conducted on active or closed cases per case manager to demonstrate compliance with regulatory requirements. These audits will be conducted one to two weeks following each quarter. The audit results will be communicated quarterly to the respective managers and supervisors. (2.1.1_Internal CCM Audit DLP)<br><br>• Correction Action Plan (CAP), "CAP, DHCS 2023 Regular Audit" (Date issued 04/09/24 demonstrates the Plan issued a CAP to its Director of Case Management Department. The Case Management Director provided remediation plan/steps to provide an outline of the steps the Department will take to address each issue identified in the root |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date *<br><br>(*Short-Term, Long-Term) | DHCS Comments |
|---|---|---|---|---|
| | 2. Update risk stratification desk level reference to define what data sources are included in risk stratification of new members.<br><br>Update existing case management policies and procedures to ensure inclusion of Health Plan risk stratification for members. The Health Plan will also review and ensure existing policy language continues to meet regulatory requirements regarding medication review for complex case management (CCM) members.<br><br>4. Conduct re-training of staff on completion of medication reviews by 6/30/2024. | | | cause analysis and Plan/Steps to avoid reoccurrence of the issue. The remediation plan start date was 08/01/23 and the remediation plan end date is 09/30/24.<br><br>• Program Description, "Complex Case Management Program Description" (FY 2022-2023) demonstrates the MCP has included Risk Stratification and Segmentation and referrals to Complex Case Management.<br><br>• Project, "External EMR Access Project" (10/07/24) demonstrates the MCP is developing a process for existing employees or new hires to gain access to medical records whether they are electronic or physical. Implementation date is 12/31/24.<br><br>**MONITORING AND OVERSIGHT**<br><br>• Template Audit Tool, "CM Audit Tool" demonstrates the Plan will conduct quarterly reviews of ongoing management of the following:<br>o Care Plan goals specific to Member's situation and needs (based on the initial assessment).<br>o Care Plan goals have Target and/or Completion Date.<br>o Care Plan goals are prioritized and reflected to Member's preferences. |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date *<br><br>(*Short-Term, Long-Term) | DHCS Comments |
|---|---|---|---|---|
| | 5. Continue to conduct case file audits to ensure medication review is completed for CCM members.<br><br>6. Updated Case Management Program Description to include risk stratification methodology. | | | ○ Barriers are specific to each goal.<br>○ Copy of Care Plan provided to Provider.<br>○ Documented Progress toward each goal.<br>○ When there is no progress over time, goal(s) are reassessed and modified as appropriate. (2.1.1_Attachment D_CM_Audit_Tool.xlsx)<br><br>• Audit Summary, "CCM File Audit Summary" (05/07/24) asked Plan to identify how many cases were audited and noncompliant.<br><br>• Audit Results, "CCM Audit Results" (Q1 – Q3 2024) demonstrates the MCP meets with each Case Manager individually to review the quarterly audit. The Case Management Manager provides feedback regarding the findings and provides coaching and education to support the learning and development of the Case Manager. Audit results from Q1-Q3 average was 83.62% compliant.<br><br>• Review, "Quarterly Review, Referrals from CCM" (Q2 and Q3 2024) demonstrates the MCP conducted quarterly reviews of referrals from CCM. The member's risk score is based on the inclusion of data from DHCS' All Payer Claims Database (APCD) 2024. In Q2, there was a total of 21 referrals from CCM and Q3, a total of 33 referrals from CCM (increased since the inclusion of the ACPD). |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date *<br><br>(*Short-Term, Long-Term) | DHCS Comments |
|---|---|---|---|---|
| | | | | **TRAINING**<br><br>• Staff Training, "CCM Refresher Training" (06/27/24) demonstrates the Plan provided training to Case Management Director, Manager, Supervisor, Lead, and RNs with regard to completion of CMP reviews.<br><br>**The corrective action plan for finding 2.1.2 is accepted.** |

## 6. Administrative and Organizational Capacity

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date * (*Short-Term, Long-Term) | DHCS Comments |
|---|---|---|---|---|
| **6.2.1 Fraud, Waste, or Abuse Reporting to DHCS**<br><br>The Plan did not report all suspected fraud and abuse incidents to DHCS within ten working days of the date the Plan first became aware of, or was on notice of, such activity. | 1. Edited DLP to define the date of discovery and how to track it in the case management system.<br><br>2. Train staff on updated process as defined in the desk level procedure.<br><br>3. Inform staff of the expectation to follow the desk level procedure. | CAP Form_6.2.1 FWA Reporting to DHCS<br><br>Attachment A_DLP PIU Case Processing.docx<br><br>Attachment B_FWA PIU Meeting Agenda_04.10.2024_Redacted.pdf<br><br>Attachment C_FWA Training Attestation.docx | Short-Term:<br><br>04/10/2024<br><br>(Completed) | The following documentation supports the MCP's efforts to correct this finding:<br><br>**POLICIES AND PROCEDURES**<br><br>• Plan policy, "CMP05: Fraud Waste and Abuse" (revised 03/04/2021) already included language stating that the Plan must report to DHCS all cases of suspected and/or credible FWA when there is reason to believe an incident has occurred, and that suspected and/or credible FWA incidents will be reported within ten working days. (DHCS Medical Audit Report, page 14)<br><br>• Desktop Procedure, "DLP_RM010: Program Integrity Unit – FWA Lead & Case Process" (revision date 5/30/2024), was revised to define the date of discovery will be the date the lead was created. The revision in the Plan's DLP addresses the gap that contributed to the audit finding. (6.2.1_Attachment E_DLP PIU Case Processing.docx, Section V. (A)(A), page 10)<br><br>**TRAINING**<br><br>• The Plan provided Meeting Agenda "Risk Management Team |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date * (*Short-Term, Long-Term) | DHCS Comments |
|---|---|---|---|---|
| | | | | Meeting" held on April 10, 2024, which provides evidence of documented review and discussion of updated changes made to the Plan's FWA Case Processing DLP. (Attachment B_FWA PIU Meeting Agenda_04.10.2024_Redacted.pdf)<br><br>• A sample Attestation was provided to demonstrate that staff training was provided on updated FWA Case Processing DLP. The Plan's Compliance Manager and trainee(s) are required to sign and date Attestation. (Attachment C_FWA Training Attestation.doc)<br><br>**MONITORING AND OVERSIGHT**<br><br>• "Corrective Action Plan (CAP)" Date Issued: 04/09/24, demonstrates that Quality Control processes and steps have been updated and expanded to monitor compliance and that controls are in place to prevent future non-compliance. (6.2.1_CAP Form_6.2.1 FWA Reporting to DHCS, page 3)<br><br>• Sample audit form, "SIU Case File Audit Form" as evidence that the Plan is conducting quarterly audits to demonstrate compliance with the Plan's DLP and that timelines are within contractual requirements. (6.2.1_Attachment D_Case File Audit |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date *<br><br>(*Short-Term, Long-Term) | DHCS Comments |
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| | | | | Form)<br><br>• The Plan provided a tracking report "Fraud, Waste, Abuse Status Report: Preliminary, Active, and Completed Investigations" which includes sections for "Date Discovered, Initial MC609 Submit Date, and Initial MC609 Timely?" All cases are monitored by the Manager, and if deficiencies are identified in reporting, a root cause is determined, solutioned, and additional action is taken to avoid recurrence. (6.2.1_Attachment F_Consolidated Report.xlx)<br><br>**The corrective action plan for finding 6.2.1 is accepted.** |

**SSS. State Supported Services**

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date * (*Short-Term, Long-Term) | DHCS Comments |
|---|---|---|---|---|
| **SSS.1 Misdirected Claims**<br><br>The Plan did not forward misdirected claims within ten working days of receipt. | 1. Phase 1 (1-6 months) – Develop Edifics Rules Engine, pre-submission scrubbing enhancement, initial exception report creation:<br>Member Matching has been implemented successfully in the legacy inbound 837 process. (Completed)<br>b. The legacy inbound 837 process assessment has been completed. (Completed)<br>c. The enhancement inbound 837 process is in development (1-6 months)<br>d. Implementing Service Code Remediation (1-6 months)<br><br>2. Phase 2 (6-9 months) – | CAP Form_SSS.1 Misdirected Claims<br><br>Attachment A_CLMS12 Misdirected Claims_APL23-020<br><br>Attachment B_Strategy to Resolve Misdirected Claims | Long-Term:<br><br>01/01/2025<br><br>(On Track – The Health Plan has initiated remedial action and is on the way towards achieving an acceptable level of compliance.) | The following documentation supports the MCP's efforts to correct this finding:<br><br>**POLICIES AND PROCEDURES**<br><br>• Updated P&P, "CLMS12: Misdirected Claims" to reflect verbiage of the APL 23-020, Requirements for Timely Payment of Claims. The Plan will forward at least 95 percent of emergency service and care claims that were misdirected to The Plan to the appropriate delegate within ten (10) working days of the receipt of the claim. The Plan will forward at least 95 percent of non-emergency services and care claims to delegate within ten (10) working days or send a notice of denial, with instruction to bill the appropriate delegate within ten (10) working days of the receipt of the claim when it was sent to The Plan erroneously in accordance with APL Requirements for Timely Payment of Claims. (CLMS12 Misdirected Claims APL 23-020).<br><br>• Desktop Procedure, "HPSJ Inbound 837 – Edifecs Implementation" as evidence that the MCP implemented the Edifecs Rules Engine in their claims system. The MCP receives electronic claims in the form of EDI 837P/I from Delegated and Non-Delegated Trading Partners |

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| | Educate Providers about new enhancements Create clear training materials on billing procedures, coding rules, and how to avoid errors that cause misdirected claims. Offer proactive educational programs for providers.<br><br>3. Phase 3 (10-12 months) – Workflow launch, Misdirected Claim Attestation, ongoing monitoring, and process improvement. | | | and Clearing Houses. These files are split at the claim level and a basic SNIP level validation is performed on them. All good claims are further validated for member eligibility and are then staged into the EDI STAGING DB. All bad claims are batched and reported. (EDI 837 Claims Staging Design Document).<br><br>• Screenshots, "Member Matching" and "Legacy Inbound 837 Process Assessment" as evidence that the Member Matching and Legacy Inbound 837 Process Assessment has been completed by the MCP. The screenshot includes the profile that executes the member matching in the 837 Inbound profiles. (Evidence of Completion).<br><br>• Written Response by the MCP (10/23/24) in which the MCP has developed a multi-layered misdirected claims process to manage claims that are submitted to the Health Plan in error within ten business days of receipt. To demonstrate timeliness is met, a claims workflow queue has been created to capture any fallout leveraging the same logic used for both vision and pharmacy claims that will be escalated to claims leadership for processing at day 1 of claims submission. On day 2 of claims aging, the claim is deemed escalated and is flagged for urgent review. This will demonstrate timeliness of claims processing of misdirected claims within the ten-day regulatory requirement. (SSS.1 Narrative Response). |

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| | | | | **MONITORING AND OVERSIGHT**<br><br>• Excel Spreadsheet, "Monthly Exceptions Report" (July 2024, August 2024, October 2024) as evidence that the MCP is able to monitor that misdirected claims were forwarded within ten working days of receipt. The report includes specific metrics that track the receipt and forwarding date of each misdirected claim, allowing the MCP to demonstrate compliance with the 10-day requirement. The Exception Report will be generated monthly to demonstrate consistent and timely monitoring. (SSS.1 Exceptions Report July, SSS.1 Claims Misdirected 202408, SSS.1 Exceptions Report October, SSS.1 Claims Attestation Front).<br><br>• "Misdirected Claim Attestation Report" (July 2024) as evidence that the MCP will now generate this report on a quarterly basis, instead of semi-annually, to demonstrate more frequent monitoring and reporting. The MCP's Claims, Provider Services, Configuration, and EDI teams will collaborate to prepare this report. (SSS.1 Claims Attestation Front Page).<br><br>**The corrective action plan for finding SSS.1 is accepted.** |

**Submitted by:** Tamara Hayes
**Title:** Director of Compliance

**Signed by:** [Signature on file]
**Date:** 05/10/2024