State of California—Health and Human Services Agency
Department of Health Care Services

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

January 5, 2023

Sandra Holzner, Compliance Officer
AIDS Healthcare Foundation
6255 West Sunset Blvd., 21st Floor
Los Angeles, CA 90028

RE: Department of Health Care Services Medical Audit

Dear Ms. Holzner:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of AIDS Healthcare Foundation, a Managed Care Plan (MCP), from April 23, 2021 through June 11, 2021. The audit covered the period of January 1, 2020 through December 31, 2020.

All items have been 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 report and the enclosed documents 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]

Oksana Meyer, MPA

Chief, CAP Compliance & FSR Oversight Section
Managed Care Quality & Monitoring Division
Department of Health Care Services

Enclosures: Attachment A (CAP Response Form)

cc: Lyubov Poonka, Chief
CAP Compliance Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

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

Nicole McQuade, Contract Manager
Medi-Cal Managed Care Division
Department of Health Care Services

ATTACHMENT A
Corrective Action Plan Response Form

Plan: AIDS Healthcare Foundation **Review Period: 1/1/2020-12/31/2020**

Audit Type: Medical Audit and State Supported Services **On-site Review: 2/8/2021- 2/19/2021**

MCPs are required to provide a CAP and respond to all documented deficiencies within 30 calendar days, unless an alternative timeframe is indicated in the letter. MCPs are required to submit the CAP in word format that will reduce turnaround time for DHCS to complete its review.

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. For deficiencies that require short-term corrective action, implementation should be completed within 30 calendar days. For deficiencies that require long-term corrective action or a period longer than 30 calendar days for implementation, the MCP must demonstrate it has taken remedial action and is making progress toward achieving an acceptable level of compliance. The MCP will be required to include the date when full compliance is expected to 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.**

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.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
1. Utilization Management				
1.3.1 Compliance with and Implementation of Supplement to APL 17-006 - The Plan did not notify a member related to a NAR that they have an additional 120 days over and above the initial 120 days allowed to request a SFH; the Plan did not comply with this requirement. In an interview, the Plan stated the Plan's Administrator and Compliance Department were aware of this APL Supplement via their usual monitoring process. The current finding indicates an apparent failure in Plan standard procedure for communicating APL and related information regarding NAR to the appropriate departments in their organization that would be integrated into the designated operations. The Plan was not certain of the exact root cause of this deficiency and apparently this may have been a combination of internal system	**1.3.1** Compliance has a system in place to monitor DHCS All Plan Letters (APLs) to ensure dissemination and implementation of updated guidance occurs. During the timeframe that the updated guidance of APL 17-006 Supplement was released, the Compliance Department was short staffed. Since that time, Compliance has hired additional staffing, a Compliance Specialist, who monitor's APL implementation. Additionally, AHF has hired an DHCS Contract Manager who also monitors the implementation and compliance with DHCS APL's. Additionally, the Plan	**1.3.1** 1. Template APL Log 2. PHC FR NAR-YourRights_Knox-Keene (COVID PHE Period) 3. PHC FR NOA-YourRights_Knox-Keene (COVID PHE Period)	2/12/2021	The following documentation supports the MCP's efforts to correct this deficiency: **Implementation** - The Template APL Log has been implemented which will assist in monitoring DHCS All Plan Letters including categories for summary, action items, implementation, and validation. This will ensure dissemination and implementation of updated guidance occurs. The Plan also hired additional staff to monitor APL compliance/implementation. - PHC FR NAR-YourRights_Knox-Keene (COVID PHE Period) - PHC FR NOA-YourRights_Knox-Keene (COVID PHE Period) The NAR/NOA template letters were updated to reflect the appropriate timeframe to request SFHs during the COVID-19 public health emergency. **The Corrective Action Plan for Finding 1.3.1 is accepted.**

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control deficiency and unintentional human error related to the unusual "Supplement" nature of the APL communication during the pandemic. Failure to notify members of APL's related information could negatively impact the appropriate care, service, and rights of members. **<u>Recommendation</u>:** Develop and implement operating procedures and guidance to ensure members receive timely and accurate information about their rights.	learned of the deficiency related to our template letters not containing the language that members had an additional 120 days over and above the initial 120 days allowed to request a State Fair Hearing (SFH). The Plan corrected that noted deficiency during the onsite Audit in February 2021.			
2. Case Management and Coordination of Care				
<u>Finding 2.5.1 Mental Health Screening System</u> The Plan did not have an effective policy and procedure for monitoring and tracking to ensure that mental health screening of members is conducted by network PCPs. During the interview, the Plan stated that network PCPs conducted	**<u>2.5.1</u>** The Plan developed a mental health screening monitoring report. The monitoring report will be a standing agenda item at the quarterly Managed Care Compliance Committee Meeting and	**<u>2.5.1</u>** 1. PQ9 Monitoring Report 2. MCCC Q1 2021 Meeting Agenda 3. DOM MC JOM ~ AGENDA	7/14/2021	The following documentation supports the MCP's efforts to correct this deficiency: **Policies & Procedures** - Updated P&P, "CM 42.3: Mental Health Services" (07/13/21) which has been updated to incorporate monitoring of the network PCP's to ensure mental health screening are being conducted.

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mental health screening of members for mental disorders with Patient Health Questionnaire-2 (PHQ-2) and PHQ-9 tools as a part of IHA and follow-up visit. The Plan's staff stated that they track completion of the mental health screening assessment through billing "G Code". A verification study consisted of a review of 11 members, six IHA and five follow-up visits from PCPs. All the screening records indicated the score of "0" for IHA and follow-up member visits. In addition, a score of "0" was found for members with psychiatric or without psychiatric disorders indicating that inadequate or no screening was performed by PCPs. The Plan stated that some PCPs failed to code the "G code" on billing claims. Based on information provided by the Plan, the procedure and monitoring system was not adequate. Without a system in place to	the monthly Department of Medicine (DOM) meetings to ensure that the PCPs are conducting mental health screenings. Additionally, Policy and Procedure CM 42.3 PHC-CA Mental Health Services was updated to reflect the updated monitoring process.	(Draft) 08.12.2021 4. Policy and Procedure CM 42.3 PHC-CA Mental Health Services		- Meeting Agenda, "Managed Care Compliance Committee (MCCC) Meeting Agenda" (07/15/21) and "Department of Medicine (JOM) Meeting Agenda" (08/12/21) as evidence the MCP is in compliance with their P&P's. **Monitoring** - Monitoring/Tracking Report, "PHQ2/9" (01/01/21 – 07/12/21) is a monitoring/tracking tool for detecting if beneficiaries are receiving mental health screenings from their PCP. This report will be a standing agenda item at the quarterly Managed Care Compliance Committee (MCCC) and monthly Department of Medicine (DOM) meetings to discuss if PCP's are conducting mental health screenings. **The Corrective Action Plan for Finding 2.5.1 is accepted.**

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ensure that PCPs conduct mental health screening of members, members may not receive the services that they need. **<u>Recommendation</u>**: Revise the process and monitoring system to ensure that PCPs conduct mental health screening of members.				
3. Access and Availability of Care				
3.8.1 Medi-Cal Enrollment of NEMT and NMT Providers - The Plan did not ensure that contracted NEMT and NMT providers were enrolled in the Medi-Cal Program. The Plan has policies and procedures requiring NEMT and NMT network providers to be screened for Medi-Cal enrollment in accordance with APL requirements prior to contracting with the Plan. However, the Plan's staff, responsible for enrolling transportation providers,	**<u>3.8.1</u>** The Plan currently <u>only</u> utilizes the contracted NEMT and NMT vendor, Call the Car, who is Medi-Cal enrolled. Per the APL 17-010 Transportation FAQ, the guidance states that the Plan is not responsible to credential non-traditional NMT drivers such as taxi, Lyft and Uber drivers to provide NMT services to its members. Therefore,	**<u>3.8.1</u>** **1.** Policy and Procedure CR 6.1 PHC-CA Provider Screening and Enrollment **2.** Policy and Procedure CR 5.0 PHC-CA Transportation Provider Credentialing Policy	3/1/2021	The following documentation supports the MCP's efforts to correct this deficiency: **Policies & Procedures** • The Plan updated its P&P "PHC-CA FDR Oversight" to address the gap that contributed to the deficiency. (Approved by MCOD 09/16/2022) The Plan will monitor & impose corrective action if non-compliance is identified. (Page 2, section C., E., F., G.) **Oversight/Implementation & Monitoring** The Plan identified, developed and deployed an internal auditing process to continuously self-monitor to detect and prevent future non-compliance:

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accepted the submission of the application to PED as confirmation of enrollment in the Medi-Cal program and did not follow the Plan's policy and procedure. During the interview, the Plan's staff stated that all network providers were enrolled in the Medi-Cal program. However, review of 29 NEMT and NMT files determined that four providers who provided NEMT and NMT transportation services to members were not either enrolled in the Medi-Cal program yet, or did not have a confirmation email or letter from PED in accordance with APLs requirements. Medi-Cal members may be subjected to substandard transportation services if a NEMT and NMT provider does not undergo the screening process to qualify as a Medi-Cal provider. **<u>Recommendation:</u>** Implement policies, procedures, and monitor to ensure that network	the Plan is compliant with DHCS' NEMT and NMT guidelines. Additionally, AHF has policy and procedures in place to ensure that contracted providers are Medi-Cal enrolled.	**3.** Policy and Procedure CR 1.5 PHC-CA **4.** Credentialing and Recredentialing Program		• The Plan confirmed that the providers cited in the report have either been enrolled, are pending within 120-days, or have since been terminated for failure to enroll as a Medi-Cal provider. (See confirmation of DHCS enrollment.) • AHF's Transportation Roster "AHF Medi-Cal Transportation Roster 09072021" demonstrates the monitoring of 120-day compliance. • The Plan oversees monitoring activities to evaluate compliance with DHCS requirements. The Plan reviews all results from monitoring activity & conducts a risk assessment. The Plan develops and implements audit processes to evaluate compliance with applicable laws, regulations and policies and rapidly detect potential issues, problems or violations. (Page 1) **The Corrective Action Plan for Finding 3.8.1 is accepted.**

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NEMT and NMT providers are screened and enrolled in Medi-Cal program per APL requirements.				
Finding 3.8.2 NEMT Physician Certification Statement Form - The Plan did not ensure member's treating physician completed the PCS form for NEMT services during the audit period in accordance with APL requirements. During the review of ten verification study files for NEMT it was noted that the member's treating physician did not complete the PCS form provided in four files and six files did not have the form. The Plan's staff and member's treating physicians did not follow current procedures and APL requirements. Without using the PCS forms as intended and required, the Plan cannot ensure that members receive the necessary and	**3.8.2** The Plan has a policy and procedure in place to ensure that the NEMT PCS form is completed by the member's treating physician. This is discussed in Policy and Procedure CM 43.3 PHC-CA Transportation Benefit. The Plan's Provider Manual addresses the PCS Form requirement at Page 16. The Plan monitors the completion of the PCS on a PCS Form Tracker. This is monitored by the Associate Director of Care Management and	**3.8.2** 1. Policy and Procedure CM 43.3 PHC-CA Transportation Benefit 2. PHC-CA Provider Manual, Page 16 3. PCS Form Tracker 4. UMC Agenda_draft	3/31/2021	The following documentation supports the MCP's efforts to correct this deficiency: **Policies & Procedures** • Policy and Procedure CM 43.3 PHC-CA Transportation Benefit & PHC-CA Provider Manual- The policy & procedures outline the four critical components of a PCS form; Function Limitations, Justification Dates of Service, Needed Mode of Transportation, & Certification Statement (certifying medical necessity). Each outlines the requirements & responsibilities of the providers to ensure members are properly receiving transportation services, & the proper authorizations are received prior to NEMT services. **Oversight/Implementation & Monitoring** • UMC Agenda_draft - evidence showing the PCS forms have been added as a standing agenda item to review reports/monitoring. The Plan addressed the PCS Form tracker on the agenda as a standing item at the Q3 2021 UMC meeting, scheduled for September 13, 2021, and all UMC meetings moving forward.

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appropriate level of transportation services. **Recommendation:** Implement policy and procedure, Provider Manual and APL to ensure that NEMT PCS form is completed by the member's treating physician.	Utilization Management or his or her designee. The PCS Form Tracker will be a standing agenda item at the quarterly Utilization Management Committee (UMC).			• PCS Form Tracker – illustrates the Plan's monitoring system, capturing important information to ensure the proper monitoring is taking place to ensure that PCS forms are being completed when necessary. The Associate Director of Case Management/Utilization Management or his or her designee is responsible for ensuring that the PCS Form Tracker is complete & correct & that all PCS Forms are received by the Plan. The PCS Form Tracker reports are submitted quarterly to the Utilization Management Committee (UMC). The Plan has implemented a process to ensure completed/executed PCS forms are received. **The Corrective Action Plan for Finding 3.8.2 is accepted.**
Finding 3.8.3 Scheduling Transportation Services by the Plan Staff - The Plan did not have an effective process and monitoring system for its staff to provide transportation in a timely manner to members. A verification study revealed systemic problems in the provision of transportation services. A review of 26 records revealed that 13 members did not get access to services in a	**3.8.3** The Director of Member Services and Call Center Operations has worked closely with and re-trained all Member Services staff, but in particular, the Transportation Coordinator to make sure that all transportation requests are correctly	**3.8.3** 1. PHC_CA Power Point Presentation Training 2. Acknowledgement Sign-TRAINING _March 11 2021	3/31/2021	The following documentation supports the MCP's efforts to correct this deficiency: **Policies & Procedures** • PHC_CA Power Point Presentation Training: The Plan developed appropriate training materials for staff to ensure that all were understanding of the NEMT & NMT requirements ensuring there are no further staff scheduling errors & to ensure that transportation is provided in a timely manner to members.

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timely manner, due to persistent appointment booking errors or wrong mode of transportation scheduled by the Plan's Member Services Department or call center. The Plan identified staff scheduling errors in NEMT and NMT Potential Quality Issue (PQI) through call logs and grievance analysis. However, the documentation provided had insufficient information to support that the Plan's Quality Management Committee (QMC) fully implemented an effective procedure and monitoring system during the audit period to resolve the PQI issue related to the member's complaints with the Plan's staff transportation scheduling errors. When the Plan makes persistent appointment booking errors or schedules the wrong mode of transportation, this can lead to delayed medical care and treatment for members.	recorded and sent to the transportation vendor. The Director of Member Services and Call Center Operations monitors an internal Member Services transportation log that the Transportation Coordinator is responsible for, to ensure accuracy of all transportation requests. The Director of Member Services and Call Center Operations also makes sure that all transportation calls are logged and match with the internal Member Services transportation log. This monitoring process is documented in the Standard Operating Procedure (SOP) MS 502.0.0 PHC-CA Non-Emergency Medical	3. MS 502.0.0 PHC-CA Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) Services 4. Exhibit C - 2021 Transportation CA Logs 5. 05.24.2021 QMC Agenda & Meeting Minutes 6. 12.09.2021 QMC Agenda & Meeting Minutes 7. 2022 QMC Charter 8. PHC-CA Quality Improvement Program		• Standard Operating Procedure MS 502.0.0 PHC-CA Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) Services: The P&P outlines the following: a. Provides guidance to the Plan's Member Services Representatives (MSR) & Transportation Coordinators (TC) on how to properly handle Call Center calls b. The P&P outlines the Plan's Monitoring Review process, which happens on an ongoing basis through an internal Member Services transportation log to ensure the accuracy of all transportation requests. c. The P&P outlines how best to determine proper course of action to resolve member's issues, requests &/or concerns. d. The P&P includes a Transportation Intake Form Template, which includes all components necessary to properly determine the course of action for the members. • 2022 QMC Charter— a. The charter outlines the purpose of the QMC, its role, & responsibilities. b. The charter highlights the quarterly meetings & all members' part of this committee, plus the covered programs & services discussed amongst the QMC. **Training** • Acknowledgement Sign- TRAINING March 11 2021: The document ensures that member services staff attended &

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Recommendation: Revise and implement an effective quality assurance process to ensure transportation access through accuracy of appointments and appropriate determination of transportation modes.	Transportation (NEMT) and Non-Medical Transportation (NMT) Services.	9. 2021 Q2 & Q3 MPC		completed the training necessary to ensure no further scheduling errors take place. **Implementation/Oversight & Monitoring** • Exhibit C - 2021 Transportation CA Logs: The Plan monitors through the Transportation CA Log, ensuring that transportation calls are logged & match with the internal Member Services transportation log, which is monitored & reviewed by the Director of Member Services as outlined in MS 502.0.0 PHC-CA NEMT-NMT Services. Any issues are identified, they will be reported to the MPC & addressed as part of the QMC quarterly meetings. • Various QMC Agendas & Meeting Minutes o The Plan demonstrates how all transportation issues identified will be reported & addressed to the QMC on a quarterly basis. o Transportation issues are reported to the Member Provider Committee (MPC), who then provides quarterly subcommittee reports to the QMC, where then any transportation issues are reported & addressed at the QMC Quarterly meetings. **The Corrective Action Plan for Finding 3.8.3 is accepted.**

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Finding 3.8.4 Monitoring of Timely Access Services of Transportation Providers - The Plan did not have an effective process to monitor transportation providers to ensure services are provided in a timely manner. During the audit, the Plan identified NEMT and NMT provider PQI. The Plan identified PQI through call logs and member grievance analysis. The PQI related to the provider was discussed in QMC meeting minutes dated March 2020. Documentation provided had insufficient information to support that the Plan developed an effective quality assurance process to handle PQI related to transportation provider. Review of 26 grievance verification files revealed that eight files still had similar complaints related to transportation drivers not picking up members in a timely manner and cancelling appointments at the last minute. When the Plan does not fully	**3.8.4** The Plan will monitor timely access services of transportation providers starting on a bi-monthly basis and have a step-down approach to monthly monitoring, if no compliance issues are noted. The Plan is in discussions with our contracted Transportation providers to incorporate Compliance Reporting into our contract language and establish compliance standards for timely access. Once AHF has established a routine reporting system, schedule, and compliance thresholds with our contracted transportation vendors, these reports will be monitored on a quarterly basis via the Member Provider Committee (MPC) as a	**3.8.4** 1. PR 2 PHC-CA Access and Availability 2. MPC Agenda 3. 05.24.2021 QMC Agenda & Meeting Minutes 4. 12.09.2021 QMC Agenda & Meeting Minutes 5. 2022 QMC Charter 6. PHC-CA Quality Improvement Program 7. 2021 Q2 & Q3 MPC	9/15/2021	The following documentation supports the MCP's efforts to correct this deficiency: **Policies & Procedures** • PR 2 PHC-CA Access and Availability: o The P&P outlines the Plan's measures of which member access & availability to eligible services are compliant with rules, requirements & standards established. o The Plan monitors member complaints through quarterly random appointment system checks to determine effectiveness of physician appointment system, using the Provider Access & Appointment Availability Verification Survey tool. o Results will be reported through the MPC with an annual summary reported to the QMC. o The recurring reports will outline vendor compliance with transportation wait times stipulations outlined in the P&P. o The MPC/QMC is responsible for recommendations or corrective actions for any issues identified. • QM 1 PHC-CA Quality Improvement Program: o The P&P outlines the Plan's QI program purpose to monitor performance of the clinical & service initiatives, identify opportunities for improvement & implement corrective action plans to improve performance. o This policy in conjunction with the MPC/QMC meeting minutes/agendas ensures that the Plan has an effective

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implement a system to address and monitor member complaints related to transportation providers, it potentially leads to a delay in member's care and treatment. **Recommendation**: Revise, implement, and monitor effective procedures to address the provision of timely access transportation with providers.	standing agenda item. Additionally, the Plan has revised Policy and Procedure PR 2.1 PHC-CA Access and Availability t to include the transportation timely access standards and compliance monitoring.			process in place to monitor transportation providers to ensure services are provided in a timely manner. • 2022 QMC Charter— o The charter outlines the purpose of the QMC, its role, & responsibilities. o The charter highlights the quarterly meetings & all members' part of this committee, plus the covered programs & services discussed amongst the QMC **Implementation/Oversight & Monitoring** • Various QMC Agendas & Meeting Minutes o The Plan demonstrates how all transportation issues identified will be reported & addressed to the QMC on a quarterly basis. o Transportation issues are reported to the Member Provider Committee (MPC), who then provides quarterly subcommittee reports to the QMC, where then any transportation issues are reported & addressed at the QMC Quarterly meetings. • PR 2 PHC-CA Access and Availability: o The P&P outlines the Plan's measures of which member access & availability to eligible services are compliant with rules, requirements & standards established. o The Plan performs quarterly random appointment system checks to determine effectiveness of physician appointment system, using the Provider Access & Appointment Availability Verification Survey tool.

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				○ Results will be reported through the MPC with an annual summary reported to the QMC. ○ The recurring reports will outline vendor compliance with transportation wait times stipulations outlined in the P&P. ○ The MPC/QMC is responsible for recommendations or corrective actions for any issues identified. **The Corrective Action Plan for Finding 3.8.4 is accepted.**
5. Quality Management				
Finding 5.3.1 Credentialing and Recredentialing Process for Providers under Concern - The Plan did not follow to completion their policies and procedures to report to the Credentialing and Peer Review Committee when a provider came under review by the Plan. DHCS reviewers noted that an in-network provider was listed on the Plan's Fraud and Abuse Log submitted for the audit. During the interview, the Plan's Compliance Manager and Special Investigation Unit (SIU) Manager explained that the Plan identified this provider under review from the 2020	**5.3.1** The Plan has made Compliance/SIU a standing agenda items at the Credentialing Committee to ensure that any FWA issues are reported out to the appropriate channels, including any Provider's under investigation. Additionally, the SIU Standard Operating Procedure (SOP) was updated to ensure that upon receiving any credible allegations of fraud, the Credentialing	**5.3.1** 1. Credentialing Committee Meeting Agenda_06.04.2021 2. Standard Operating Procedure CO 500.0.3 AHF SIU SOP at P.18	2/17/2021	The following documentation supports the MCP's efforts to correct this deficiency: **Implementation** - Monthly Meeting, "AHF/PHP/PHC Credentialing Committee" (05/07/21, 06/04/21, 07/09/21) which provides evidence of documented review and discussion of ongoing monitoring of Providers who have come under concern to the Plan due to an investigation, disciplinary action or sanctions. In addition, the Peer Review Committee is part of the meeting agenda to address any providers under review. **Monitoring/Tracking** - An email (08/06/21) which includes a description of the MCP's process for monitoring providers under review.

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National Health Care Fraud and Opioid Takedown database. Information indicated that this provider had been indicted with intent to defraud a health care program. The SIU Manager performed an impact analysis with no finding of apparent exposure to the Plan, DHCS, or members. The Plan filed Form MC609 for the provider under review. However, the case was not forwarded to the Plan's Credentialing Department nor addressed in Peer Review Committee as required by the Plan's contract, policies, and procedures. The Plan did not have effective internal controls to ensure that there was a complete and consistent process for providers who are under review for possible misconduct. A lack of internal controls related to credentialing can lead to inadequate oversight of the Plan's provider network and increase the risk for possible member harm when	Department would be notified to ensure that the credentialing file was updated.			The SIU (Special Investigative Unit) Investigation Log tracks providers under review and is maintained by the Compliance Manager. Per the SIU SOP (Standard Operation Procedure), the manager notifies the Credentialing Committee when a credible allegation of fraud exists and documents the notification in the SIU Investigation Log. **The Corrective Action Plan for Finding 5.3.1 is accepted.**

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members receive care from practitioners who are under investigation. **Recommendation:** Develop and implement procedural controls to ensure that the Plan's credentialing process appropriately addresses providers who have come under concern to the Plan due to an investigation, disciplinary action, or sanctions.				

Submitted by: Sandra Holzner **Date: 7/14/2021**
Title: Associate Director of Internal Audit and Plan Performance