



MICHELLE BAASS  
DIRECTOR

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



GAVIN NEWSOM  
GOVERNOR

January 5, 2023

Sandra Holzner, Compliance Officer  
AIDS Healthcare Foundation  
6255 West Sunset Blvd., 21<sup>st</sup> 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 January 10, 2022 through January 21, 2022. The audit covered the period of January 1, 2021 through December 31, 2021.

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

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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:** 1/1/2021 - 12/31/2021

**Audit Type:** Medical Audit and State Supported Services

**On-site Review:** 1/10/2022 - 1/21/2022



CALIFORNIA DEPARTMENT OF  
HEALTH CARE SERVICES

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 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: 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. For policies and other documentation that have been revised, please highlight the new relevant text. 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.**

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
<b>1. Utilization Management</b>				
<p><b>1.2.1 Pre-Authorizations and Review Procedures -</b> The Plan did not ensure decisions to deny or authorize were made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease</p> <p><b>Recommendation:</b> Develop and implement policies and procedures to ensure qualified health professionals render medical review decisions.</p>	<p>The Plan will update and implement policies and procedures to further delineate which authorization requests can be approved by administrative and clinical Utilization Management (UM) staff members by September 30, 2022.</p>	<p>Policy UM35 Clinical Criteria and Guidelines</p> <p>SOP UM 502.0.0</p> <p>Policy UM 22 Authorization Referral Process</p>	<p>9/30/2022 10/7/2022 12/16/2022</p>	<p>The following additional documentation supports the MCP's efforts to correct this finding:</p> <p><b>POLICIES &amp; PROCEDURES</b></p> <p>Policy UM35 Clinical Criteria and Guidelines (Revised 10/7/22)</p> <p>Indicates Plan shall conduct utilization review using criteria and guidelines that are approved and adopted in utilization and care/case management program, including, but not limited to:</p> <ul style="list-style-type: none"> <li>a. Medi-Cal Provider Manual</li> <li>b. Evidence based criteria, InterQual and MCG</li> </ul> <p>Plan indicates it prioritizes Medi-Cal guidelines when making utilization management decisions. Per Plan policy, Medi-Cal guidelines are the highest authority of clinical criteria and guidelines utilized. If Medi-Cal guidelines are not available, then subsequent guidelines are used.</p> <p>SOP UM 502.0.0</p> <p>Details when a request requires second level and Medical Director review.</p> <p>Provides a list of service requests that can be approved by an authorization coordinator, that require a nursing review, and require Medical Director review.</p>

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				<p>Policy UM 22 Authorization Referral Process (Revised 12/16/22)</p> <p>For utilization management decisions, the Plan will ensure the following:</p> <p>“Requested health care services may be approved by UM staff who are not qualified health care professionals only when:</p> <ul style="list-style-type: none"> <li>- UM staff is under the supervision of an appropriately licensed health care professional.</li> <li>- There is explicit UM criteria</li> <li>- No clinical judgment is required”</li> </ul> <p>Requested health care services which require the use of clinical judgment shall be approved by licensed health care professionals.</p> <p>Decisions to deny or to authorize an amount, duration, or scope less than the requested health care services based in whole or in part on medical necessity are made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.</p> <p>Only physicians can render adverse determinations regarding requested services.</p> <p><b>MONITORING &amp; OVERSIGHT</b></p> <p>Plan staff was trained on DHCS/Medi-Cal guidelines and instructed to reference the specific policy/guidelines used to make UM decisions.</p>

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				<p>Policy UM 35 Clinical Criteria and Guidelines outlines monitoring and oversight responsibilities.</p> <p>Annually, the Plan will submit criteria and guidelines to the Utilization Management Committee and Quality Management Committee for review and approval.</p> <p>Annually, the Plan will conduct inter-rater reliability testing on all personnel who perform organization determinations and can issue corrective action plans to staff who score below the acceptable threshold. That Plan has a separate IRR policy.</p> <p><b>The Corrective Action Plan for Finding 1.2.1 is accepted.</b></p>
<p><b>1.2.2 Criteria Used for Medical Prior Authorization Review -</b> The Plan did not comply with requirements referenced in the Medi-Cal Provider Manual when rendering PA determinations using alternate criteria only.</p> <p><b>Recommendation:</b> Implement policies and procedures to ensure the Plan references the</p>	<p>The Plan will update and implement policies and procedures to include the Medi-Cal provider manual by September 30, 2022.</p>	<p>Policy UM 35 Clinical Criteria and Guidelines</p> <p>Policy UM 22 Authorization Referral Process</p>	<p>9/30/2022 10/7/2022 12/16/2022</p>	<p>The following additional documentation supports the MCP's efforts to correct this finding:</p> <p><b>POLICIES &amp; PROCEDURES</b></p> <p>Policy UM35 Clinical Criteria and Guidelines (Revised 10/7/22)</p> <p>Indicates Plan shall conduct utilization review using criteria and guidelines that are approved and adopted in utilization and care/case management program, including, but not limited to:</p> <ul style="list-style-type: none"> <li>a. Medi-Cal Provider Manual</li> <li>b. Evidence based criteria, InterQual and MCG</li> </ul> <p>Plan indicates it prioritizes Medi-Cal guidelines when making</p>

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Medi-Cal Provider Manual as required.				<p>utilization management decisions. Per Plan policy, Medi-Cal guidelines are the highest authority of clinical criteria and guidelines utilized. If Medi-Cal guidelines are not available, then subsequent guidelines are used.</p> <p>Policy UM 22 Authorization Referral Process (Revised 12/16/22)</p> <p>For utilization management decisions, the Plan will ensure the following:</p> <p>Requested health care services which require the use of clinical judgment shall be approved by licensed health care professionals.</p> <p>Decisions to deny or to authorize an amount, duration, or scope less than the requested health care services based in whole or in part on medical necessity are made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.</p> <p>Only physicians can render adverse determinations regarding requested services.</p> <p><b>MONITORING &amp; OVERSIGHT</b></p> <p>Plan staff was trained on DHCS/Medi-Cal guidelines and instructed to reference the specific policy/guidelines used to make UM decisions.</p> <p>Policy UM 35 Clinical Criteria and Guidelines outlines monitoring and oversight responsibilities.</p>

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				<p>Annually, the Plan will submit criteria and guidelines to the Utilization Management Committee and Quality Management Committee for review and approval.</p> <p>Annually, the Plan will conduct inter-rater reliability testing on all personnel who perform organization determinations and can issue corrective action plans to staff who score below the acceptable threshold. That Plan has a separate IRR policy.</p> <p><b>The Corrective Action Plan for Finding 1.2.2 is accepted.</b></p>
<p><b>1.2.3 Clear Documentation of Reasons for Medical Authorization Decisions</b> - The Plan did not clearly document reasons for its decisions on approved medical PAs.</p> <p><b>Recommendation:</b> Develop and implement policies and procedures to ensure decisions are clearly documented.</p>	<p>The Plan will update policies and procedures to ensure criteria for decision making is clearly documented by September 30, 2022.</p>	<p>UM 35 Clinical Criteria and Guidelines</p>	<p>9/30/2022 10/7/2022</p>	<p>The following additional documentation supports the MCP's efforts to correct this finding:</p> <p><b>POLICIES &amp; PROCEDURES</b></p> <p>Policy UM35 Clinical Criteria and Guidelines (Revised 10/7/22)</p> <p>Indicates Plan shall conduct utilization review using criteria and guidelines that are approved and adopted in utilization and care/case management program, including, but not limited to:</p> <ul style="list-style-type: none"> <li>a. Medi-Cal Provider Manual</li> <li>b. Evidence based criteria, InterQual and MCG</li> </ul> <p>Plan indicates it prioritizes Medi-Cal guidelines when making utilization management decisions. Per Plan policy, Medi-Cal guidelines are the highest authority of clinical criteria and guidelines utilized. If Medi-Cal guidelines are not available, then subsequent</p>



Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				<p>guidelines are used.</p> <p><b>MONITORING &amp; OVERSIGHT</b></p> <p>Plan staff was trained on DHCS/Medi-Cal guidelines and instructed to reference the specific policy/guidelines used to make UM decisions.</p> <p>Policy UM 35 Clinical Criteria and Guidelines outlines monitoring and oversight responsibilities.</p> <p>Annually, the Plan will submit criteria and guidelines to the Utilization Management Committee and Quality Management Committee for review and approval.</p> <p>Annually, the Plan will conduct inter-rater reliability testing on all personnel who perform organization determinations and can issue corrective action plans to staff who score below the acceptable threshold. That Plan has a separate IRR policy.</p> <p><b>The Corrective Action Plan for Finding 1.2.3 is accepted.</b></p>
<p><b>1.3.1 Appeal Timeframe Information for Providers</b> - The Plan did not include the timeframe of 60 calendar days from the date of the NOA for filing an appeal in the Provider Manual.</p>	<p>The Plan revised the PHC California Provider Manual. See P.81, section 12.4 Member Appeals and Grievance of the Provider Handbook.</p>	<p>PHC Provider Manual_revised</p>	<p>June 29, 2022</p>	<p>The following additional documentation supports the MCP's efforts to correct this finding:</p> <p><b>POLICIES &amp; PROCEDURES</b></p> <p>- Revised PHC Provider Manual demonstrates the MCP made the necessary updates to its provider manual. The provider manual now states: "The appeal timeframe is sixty (60) days from the date of the</p>

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
<p><b>Recommendation:</b> Revise the Provider Manual to include the 60-calendar day timeframe to file an appeal.</p>				<p>NOA” (page 82, section 12.4)</p> <p><b>The Corrective Action Plan for Finding 1.3.1 is accepted.</b></p>
<p><b>1.5.1 Annual Oversight of a Delegated Entity -</b> The Plan did not maintain a system to evaluate its delegated functions. The Plan did not follow its procedures to perform an annual audit of its delegate during the audit period.</p>	<p>The Plan will complete a delegation oversight audit of Magellan by December 31, 2022.</p>	<p>N/A</p>	<p>December 31, 2022</p>	<p>The following additional documentation supports the MCP’s efforts to correct this finding:</p> <p><b>POLICIES &amp; PROCEDURES</b></p> <p>- Document request for delegation oversight audit of Magellan demonstrates the MCP has initiated its process to begin its audit process of its delegated entity to be completed 12/31/22.</p> <p><b>The Corrective Action Plan for Finding 1.5.1 is accepted.</b></p>
<p><b>2. Case Management and Coordination of Care</b></p>				
<p><b>2.5.1 Alcohol or Substance Abuse Treatment -</b> The Plan does not have policies and procedures for identification, referral, and coordination of care for members requiring alcohol or substance</p>	<p>The Plan will update and implement policies and procedures to include identification, referral, and coordination of care for members requiring alcohol or substance abuse treatment services by September 30, 2022.</p>	<p>1. UM 34 “PHC-CA Substance Abuse Disorder Treatment Services”</p> <p>2. “PHC Mental Health Report”</p>	<p>September 30, 2022</p>	<p>The following additional documentation supports the MCP’s efforts to correct this finding:</p> <p><b>POLICIES &amp; PROCEDURES</b></p> <p>The MCP updated P&amp;Ps to address the gap that contributed to the deficiency. The final approved copy of UM 34 “PHC-CA Substance Abuse Disorder Treatment Services” included identification, referral, and coordination of care for members requiring alcohol or substance</p>

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
<p>abuse treatment services.</p> <p><b>Recommendation:</b> Develop and implement policies and procedures for identification, referral, and coordination of care for members requiring alcohol or substance abuse treatment services.</p>				<p>abuse treatment services. (Approved 12/1/22)</p> <p><b>MONITORING &amp; OVERSIGHT</b></p> <p>- “PHC Mental Health Report” (Review period 1/1/22 - 11/30/22), a copy of the Plan’s monitoring report, which displays eligible members and percent of completed treatment services.</p> <p><b>The Corrective Action Plan for Finding 2.5.1 is accepted.</b></p>
<b>3. Access and Availability of Care</b>				
<p><b>3.8.1 NEMT and NMT Provider Enrollment</b> - The Plan did not ensure that contracted NEMT and NMT providers were enrolled in the Medi-Cal Program.</p> <p><b>Recommendation:</b> Implement policy and procedures to monitor and ensure NEMT and NMT providers in the Plan’s network are enrolled in the Medi-Cal</p>	<p>The Managed Care Plan’s (MCP) transportation vendor, Call the Car (CTC) is a Medi-Cal registered provider. The MCP uses CTC exclusively for NEMT and for some NMT. THE MCP also uses Lyft, which is conditionally approved by Medi-Cal.</p> <p>The Plan is contesting this finding. The Plan’s</p>	<p>1. FW_ Transportation Roster Guidance from DHCS</p> <p>2. PHC-CA Provider Screening and Enrollment</p>	<p>November 10, 2021</p>	<p>The following additional documentation supports the MCP’s efforts to correct this finding:</p> <p><b>POLICIES &amp; PROCEDURES</b></p> <ul style="list-style-type: none"> <li>The Plan updated its P&amp;P “PHC-CA FDR Oversight” to address the gap that contributed to the deficiency. (Approved by MCOB 09/16/2022) The Plan will monitor &amp; impose corrective action if non-compliance is identified. (Page 2, section C., E., F., G.)</li> </ul> <p><b>MONITORING &amp; OVERSIGHT</b></p> <p>The Plan identified, developed and deployed an internal auditing process to continuously self-monitor to detect and prevent future non-compliance:</p>

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
Program.	<p>current Provider Screening and Enrollment policy and procedures outlines the Plans current process for monitoring Medi-Cal provider enrollment requirements to ensure compliance with State regulations.</p> <p>The Plan received guidance from DHCS MCQMD on November 10<sup>th</sup>, 2021, advising that MCP's should not immediately terminate transportation provider contracts as a request of delays associated with transportation providers securing Medi-Cal enrollment approvals to ensure transportation access needs are met for Plan enrollees. The Plan has attached a copy of this communication received from DHCS</p>			<ul style="list-style-type: none"> <li>• 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.)</li> <li>• AHF's Transportation Roster "AHF Medi-Cal Transportation Roster 09072021" demonstrates the monitoring of 120-day compliance.</li> <li>• The Plan oversees monitoring activities to evaluate compliance with DHCS requirements. The Plan reviews all results from monitoring activity &amp; 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)</li> </ul> <p><b>The Corrective Action Plan for finding 3.8.1 is accepted.</b></p>

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	MCQMD as a reference.			
<b>4. Member Rights</b>				
<p><b>4.1.1 Grievance Resolution</b> - The Plan did not resolve grievances within the required 30 calendar days.</p> <p><b>Recommendation:</b> Revise and implement policy and procedures to be consistent with APL requirements and ensure grievance resolutions are sent to members within the required timeframe</p>	<p>The Plan Policy and Procedure has been revised and systematic updates have been implemented to clearly indicate the grievance processing timeframe to align with the APL 21-011 and the (CCR, Title 22, section 53858(g)(1)) requirements. After the deficiency was identified, the Grievance and Appeals Department made all efforts to ensure that grievance resolution letters are sent to members within the thirty (30) days required timeframe. All Grievance Coordinators have been educated to ensure grievance resolution letters are mailed timely to members.</p>	<p>PHC-California Member Grievance Process</p>	<p>June 28, 2022</p>	<p>The following additional documentation supports the MCP's efforts to correct this finding:</p> <p><b>POLICIES &amp; PROCEDURES</b></p> <p>- Revised P&amp;P, "RM 7 – PHC California Member Grievance Process" (02/24/22) which has been amended to address timeliness of resolutions letter to member per APL 21-011. (Section 9.e) "PHC will mail a written response of resolution to grievances within thirty (30) calendar days of receipt. Even though federal regulations allow for a fourteen (14) calendar day extension for standard and expedited appeals, this allowance does not apply to grievances. In the event that resolution of a standard grievance is not reached within thirty (30) calendar days as required, PHC must notify the member in writing of the status of the grievance and the estimated date of resolution."</p> <p>Above said P&amp;P, "RM 7 – PHC California Member Grievance Process" commits the Plan to resolve all grievances within the required 30 calendar days: "Member grievances shall be resolved within thirty (30) days of the member's submittal of a written grievance or if the grievance is made verbally, it shall be resolved within thirty days of the written record of the grievance." (Section 9.a.i)</p> <p><b>TRAINING</b></p> <p>- Training screenshots "Salesforce RBO Response Training" and a</p>

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				<p>written response from the Plan demonstrate the system in place to create grievance alerts through Salesforce, Domo &amp; Formstack for all RBO's &amp; Regionals. The reviewer will receive notification of pending, current open grievances and can access all member grievance issues in one place (member portal).</p> <p>- The attestation form "Grievance Training Completions by AHF University" confirms G&amp;A staff completing the training in April 2022.</p> <p><b>MONITORING &amp; OVERSIGHT</b></p> <p>- A sample spreadsheet, "MCPDIP_Grievances_New Template_20220418," tracks the status of the grievance (Grievance Receipts Date, Resolutions Status Indicator, and Resolutions Date). A subsequent tracker, "CA Grievance Issues Unresolved Over 30 Days," follows the grievance that was not resolved timely (30 days) for a required notification letter to notify the member in writing of the status of the grievance and the estimated date of resolution. The tracker displays: The grievance Receipt Date, Days Open, Notification Date, Resolution Date, and Status.</p> <p>- A sample screenshot, "GV-22-XXXX," demonstrates the system's capability to track Grievance resolution for timeliness.</p> <p><b>The Corrective Action Plan for Finding 4.1.1 is accepted.</b></p>
<b>5. Quality Management</b>				
<b>5.3.1 New Provider Training</b> - The Plan did	The Plan created a Standard Operating	PHC-CA Provider Orientations SOP	June 28, 2022	The following additional documentation supports the MCP's efforts to correct this finding:

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<p>not ensure new providers received training within ten business days after placing the contracted providers on active status. The Plan did not define the active status date in its policies and procedures.</p> <p><b>Recommendation:</b> Update Plan policy to define the active status date and develop a process to ensure all providers receive training within ten working days.</p>	<p>Procedure outlining the requirements and processes associated with all new provider orientations to ensure completion of orientations within the ten (10) working day requirement.</p>			<p><b>POLICIES &amp; PROCEDURES</b></p> <p>“PHC-CA Provider Relations” (08/18/22) in which the MCP outlines the requirements and processes associated with all new provider orientations to ensure completion of orientations within the ten (10) working day requirement. In addition, the MCP has implemented an Excel Provider Orientation Log to reflect the completed orientations, summary of accuracy and timeline completion to the quarterly Member Provider Committee meetings, and audit results of the Health Suite system effective date detail in comparison to the Provider Orientation log to confirm accuracy and completion of orientations. The timeline for effective date determination are as follows: All California contracts will be approved and counter signed before the 10th of each month, contract orientation deadlines will be identified within ten (10) days post contract counter signature date. (PHC-CA Provider Orientations SOP, Page 2).</p> <p><b>MONITORING</b></p> <ul style="list-style-type: none"> <li>- Excel Spreadsheet, “Provider Relations Training Log” as evidence that the MCP is monitoring to ensure new providers completed the required training. The Provider Relations Training Log tracks and monitors the following elements: Provider Name, Provider Specialty, Contract Effective Date, Orientation Date, Orientation Attendees (PR Training Log).</li> <li>- “Audit of Provider Training Orientation Forms” as evidence that the MCP has conducted an audit of the Provider Training Orientation</li> </ul>

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				<p>Forms and accompanying HealthSuite data entry for the time period of January 2022 – April 2022. The deadline to complete Provider Training was reviewed to ensure that the Plan’s Providers are trained within ten (10) days after Contract Effective Date. The Plan will continue to audit the Provider Orientation Forms and attestations on a monthly basis via Salesforce, and ensure the data is accurately inputted into HealthSuite (PR Training Audit 01.01.01-04.30.2022).</p> <p><b>The Corrective Action Plan for Finding 5.3.1 is accepted.</b></p>
<b>6. Administrative and Organizational Capacity</b>				
<p><b>6.2.1 Fraud and Abuse Reporting -</b> The Plan did not report preliminary investigations of suspected cases of fraud and abuse to DHCS within ten working days.</p> <p><b>Recommendation:</b> Implement policies and procedures to ensure preliminary investigations of suspected cases of fraud and abuse are reported within the</p>	<p>The Plan updated the Special Investigations Unit (SIU) SOP to reflect the recommendations: That preliminary investigations of suspected fraud and abuse will be reported to DHCS within ten (10) working days. See P. 5.</p>	<p>Special Investigations Unit SOP</p>	<p>August 18, 2022</p>	<p>The following documentation supports the MCP’s efforts to correct this finding:</p> <p><b>POLICIES &amp; PROCEDURES</b></p> <p>- Updated P&amp;P, “Special Investigations Unit” (08/18/22) that preliminary investigations of suspected fraud and abuse will be reported to DHCS within ten (10) working days (PHC-CA Provider Orientations SOP, Page 5).</p> <p><b>TRAINING</b></p> <p>- Training Slides, “Fraud, Waste, and Abuse Training” which informs MCP staff on how to detect, correct, and prevent fraud, waste, and abuse (FWA Training).</p> <p><b>MONITORING &amp; OVERSIGHT</b></p>



Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
required timeframe.				<p>- Excel Spreadsheet, "Special Investigations Unit (SIU) Log - 2022" as evidence that the MCP is monitoring cases of fraud and abuse. The SIU Log tracks and monitors the following elements: Provider/Member Name, Date Referral Received, Preliminary Investigation Start Date, Lead Details, Status, Date Regulatory Agency Notified, Date Closed (PHC-CA Log 2022).</p> <p><b>The Corrective Action Plan for Finding 6.2.1 is accepted.</b></p>

Submitted by: [Plan's Signature on File]  
Title: Sandra Holzner, Compliance Officer

Date: August 18, 2022