ATTACHMENT A
Corrective Action Plan Response Form

Plan: Health Plan of San Mateo

Audit Type: DHCS Cal MediConnect **Review Period: 11/1/17 – 9/30/18**

MMPs 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. MMPs may respond by using the DHCS Secure File Transfer Protocol (SFTP) by placing the submission into the folder marker 'Medical Audit CAP.' MMPs may also submit the CAP via email to MCQMD_CAPs@dhcs.ca.gov in Word format.

The CAP response must include a written statement identifying the deficiency and describing a plan of action to correct deficiencies, and the projected operational results expected from that action. For deficiencies that require a long-term correction or more than 30 days to remedy and operationalize, the MMP must demonstrate an interim short-term solution and provide a timeline toward achieving an acceptable level of compliance. The MMP is required to include a projected date to achieve full compliance. Any policy and/or procedure submitted during the CAP process must be sent to the MMP's Contract Manager for review and approval in accordance with existing requirements.

DHCS will maintain close communication with the MMP throughout the CAP process and provide technical assistance to ensure the MMP provides sufficient documentation to correct deficiencies.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Short-Term Implementation Date	Long-Term Implementation Date	DHCS Comments
1. Utilization Management					
1.2.1 Timeframe for Processing Routine Authorizations The Plan's process for reviewing routine prior authorizations did not	HPSM updated its prior authorization procedures. Decisions for Medi-Cal and CareAdvantage routine authorizations	1. UM.008 Prospective Prior Authorization Reviews	03/25/2019	03/25/2019	**05/22/19** – The following documentation supports the MMP's efforts to correct this finding: - Updated P&P, "UM.008: Prospective Prior

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meet the contract requirement of adjudicating within five working days.	will be made within 5 working days.				Authorization Reviews" (03/25/19) which has been amended to include that routine prior authorizations are processed and decisions are rendered within five working days for Medi-Cal and Care Advantage members (page 2-3). **08/22/19** – The following additional documentation supports the MMP's subsequent efforts to correct this finding: -Updated P&P, "UM:004: Prospective Prior Authorization Reviews" (08/16/19) which has been amended to include additional language that prior authorizations are processed within five working days, but no longer than 14 calendar days from the receipt of the request for Medi-Cal and

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					CA CMC members, as referenced by Contract, Section 2.11.7.5 (page 3). **This finding is closed.**
1.2.2 Retrospective Reviews The Plan did not process retrospective review of authorizations for CMC members.	HPSM will process retrospective review of authorizations for Medi-Cal primary services.	1. HS.001 Retrospective Review of Authorizations	05/06/2019	05/06/2019	**05/22/19** - The following documentation supports the MMP's efforts to correct this finding: - Policy HS.001 was revised to ensure that retrospective reviews will take place for Medi-Cal primary services. **This finding is closed**
1.2.3 Provider Manual The Plan did not update its provider manual to include the new timeframe of 60 days for filing an appeal.	HPSM updated the provider manual to reflect accurate grievance filing timeframes.	1. Provider Manual Section 3 pg. 6	05/15/2019	05/15/2019	**05/22/19** – The following documentation supports the MMP's efforts to correct this finding: - Updated Provider Manual (05/02/19) that reflects the new timeframe for filing an appeal within 60 calendar days for Medi-Cal and

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					CareAdvantage members. **This finding is closed.**
2. Case Management and Coordination of Care					
2.4.1 Non-Emergency Medical Transportation Services The Plan did not require prior authorizations for NEMT services as described in DPL 18-001.	HPSM will implement a prior authorization requirement for NEMT services. Notice was sent to HPSM's providers on 05/01/2019 regarding this new prior authorization requirement. A follow-up notice was sent to HPSM's providers on 05/16/2019 notifying them that the prior authorization requirements would be effective 7/1/2019 following system testing.	1. Provider NEMT Requirement Notification 2. HPSM NEMT Form 3. Follow-Up NEMT Requirement Notification	07/01/2019	07/01/2019	**05/22/19** - The following documentation supports the MMP's efforts to correct this finding: - Provider NEMT Requirement Notification was sent to providers to inform them of the prior authorization requirements for NEMT. - HPSM NEMT PCS form to be used to obtain NEMT prior authorization. - HPSM NEMT Prior Authorization Update notifying providers that prior authorization requirements for NEMT will be effective July 1, 2019

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					07/02/19 - The following additional documentation supports the MMP's efforts to correct this finding: - Policy UM-004 was updated to require prior-authorization for NEMT. **This finding is closed.**
2.4.2 Physician Certification Statement The Plan's policy did not include procedures to obtain a PCS form and the required data as listed in DPL 18-001. The Plan did not use a DHCS approved PCS form nor did they have a mechanism to capture and submit data for NEMT	The PCS form was submitted to DHCS on 3/18/2019 and approved on 4/9/2019. The form will be implemented with the NEMT Prior authorization requirement.	1. PCS Form	07/01/2019	07/01/2019	**05/22/19** - The following documentation supports the MMP's efforts to correct this finding: - DHCS approved PCS form will be used for NEMT prior authorization starting July 1, 2019. **07/02/19** - The following additional documentation supports the MMP's efforts to correct this finding: **07/02/19** - The following

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services.					additional documentation supports the MMP's efforts to correct this finding: - Email communication dated 7/2/19, MMP confirmed NEMT prior authorization requirement and use of PCS forms implemented as of July 1, 2019. **This finding is closed.**
3. Access and Availability of Care					
3.1.1 Accuracy of Provider Directory The Plan did not maintain an accurate provider directory. A verification study identified deficiencies related to the Plan's printed and online provider directory information.	1. HPSM revised its P&Ps to add additional data maintenance and oversight steps for Provider Services Representatives to conduct quality assurance checks of the information in the provider database (PRIME) and the	1. PS. 04	1. 01/01/2019	1. 01/01/2019	**05/22/19** – The following documentation supports the MMP's efforts to correct this finding: - Updated P&P, "PS-04: Provider Data Auditing and Provider Directories Production" (05/21/19) which has been amended to include data maintenance and oversight steps of the provider

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	claims eligibility system (HEALTHsuite), from which an extract is used to create the provider directory. 2. HPSM is currently in the User Testing phase of launching a new provider portal that allows providers to view and request corrections to their data online in a more streamlined manner. 3. HPSM is currently evaluating a new credentialing database to replace PRIME. The system would include additional quality controls to improve the				directory. **07/08/19** – The following additional documentation submitted supports the MMP's subsequent efforts to correct this finding: - Job description, "Provider Data Steward" (07/08/19) from the plan recruiting for a Provider Data Steward position whose scope would be to improve and maintain provider data. The Provider Data Steward will also act as lead data steward for provider data, making data updates in a timely manner and identifying opportunities for automating or improving data workflows. **11/18/19** – The following additional documentation submitted supports the MMP's subsequent efforts to correct this finding:

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	accuracy and completion of provider data. 4. HPSM identified that the majority of errors noted in the audit findings stemmed from provider groups to whom the Plan has delegated credentialing. To address this issue, HPSM is implementing additional reporting and oversight of steps for the review of credentialing activity to provider rosters, to increase accountability for the timeliness and completeness of provider data submitted by provider groups.				- "Detail: Data Steward" that explains the job responsibilities of the Provider Data Steward. The job responsibilities include ensuring that provider data is complete and accurate. Also, to design and implement internal processes and reporting to monitor provider data quality. **12/27/19** – The following additional documentation submitted supports the MMP's subsequent efforts to correct this finding: - Updated Workflow Chart, "Health Suite Provider Data Updates" (07/17/19) as evidence that the MMP has implemented new work flows for provider data changes. MMP staff perform additional research

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	See PS-04 3.1.2.				and provider contact to confirm changes. The Provider Network Manager reviews for completeness and accuracy. - “Health Suite Provider Data Configuration Definitions” in which the MMP has created a quick guide to define provider data types within the MMP’s directory, and their allowed provider types. This better ensures that data edits are made in all necessary places so that they appear correctly in the MMP’s directory. This guide is used by the MMP staff who either create new provider directory entries, or who edit provider demographic data. - Written statement from the MMP in which they will conduct ongoing and regular data reconciliation

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					between the two data input sources (PRIME and HEALTHSUITE) for provider data. - Calendar Meeting Invite, "Weekly Provider Data Integration Enhancement Meetings" as evidence that the MMP will implement via weekly meeting throughout 2018-2019, with IT, Business Systems Integration, and Provider Services, to review and resolve discrepancies in data (either between sources, or against data formatting standards), as part of ongoing work to enhance the integration of these two sources of data into a single source of truth. - "Reassignment of Delegated Credentialing Entities among PS Team" in which the MMP has

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					reassigned Provider Services Representatives to better distribute accountability for updating delegated provider data. The MMP states that previously most delegates were assigned to a single representative, which was a bottleneck, or did not have an assigned representative. - Written response from the MMP which states that they have re-organized the Provider Services department to assign responsibility for provider data updates in dedicated and more highly-trained staff. Requirements for this role include technical skills that were not required for any existing Provider Services role previously. **This finding is closed.**

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4. Member's Rights					
4.1.1 Grievance Resolution Timeframe The Plan did not resolve grievances within 30 calendar days.	The G&A Unit experienced staffing shortages during 2018, which contributed to the failure to resolve cases by their due date. G&A Unit has added a Coordinator II position in December 2018 to assist with case review and ensure timely resolution of all grievances. In addition, a G&A Manager was hired in November 2018, who is conducting monitoring through weekly reports.	1. Dashboard Measures of Grievance Resolution Timeliness 2. Weekly Report sample	12/01/2018	12/01/2018	**05/22/19** – The following documentation supports the MMP's efforts to correct this deficiency: - The MMP's response ("Action Taken") confirming hire of an additional G&A staff, including a G&A Manager (November 2018). - A snap shot of "Dashboard Measures of Grievance Resolution Timeliness" shows steady improvement to a 100% compliance reached in March 2019. **08/05/19** - The following additional documentation

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					supports the MMP's efforts to correct this deficiency: - A current snap shot of "Dashboard Measures of Grievance Resolution Timeliness" (08/05/19) demonstrates continues compliance in standard grievance resolution and the timely sending of grievance resolution letters. **This finding is closed.**
4.1.2 Grievance Filing Timeframe The Plan did not have an accurate grievance filing timeframe in its policies and procedures and provided that incorrect information to the providers in its informing materials.	HPSM updated provider fact sheet and P&Ps on 4/9/2019 to reflect accurate grievance filing timeframes. Staff were trained on the timeframe on 3/11/2019.	1. Staff Meeting Agenda 3/11/2019 2. Staff Meeting Sign in Sheet 3/11/2019 3. Provider Fact Sheet 4. Updated P&P	04/09/2019	04/09/2019	**05/22/19** – The following documentation supports the MMP's efforts to correct this deficiency: - P&P GA.10 "Overview of Member Complaints Process for Medi-Cal, Healthy Kids, HealthWorx and ACE" revised 03/05/19 allows Medi-Cal beneficiaries to file grievances at any time.

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					(Section 9, 9.1) - Revised "Provider Fact Sheet" (Section, "Timeframes for filing and resolving complaints" shows no time limit for filing a grievance. - "G&A Staff Meeting Agenda" and sign-in sheet (03/11/19) as evidence that G&A staff received training. The documentation address timeframes for grievance filling that is consistent with the contractual requirements. There is no time limit for filling a grievance. (Page 1 (4)) **08/06/19** – The following additional documentation supports the MMP's efforts to correct this deficiency: - Revised P&P GA.07 "Member Grievance

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					Procedure for Medi-Cal, Healthy Kids, HelathWorx, and Ace" (08/05/19) specifies that Medi-Cal members may file a grievance at any time. (Section 2.0 (2.1)) **This finding is closed.**

Submitted by: **Date:**
Title: