

MEETING AGENDA



Meeting: Governance / Compliance Committee

Date: March 17, 2026

Time: 1:00 PM -2:00 PM

Location: PHC Offices: **Partnership Offices**

- 1) 4665 Business Center Drive, Fairfield, CA (Shasta)
- 2) 2525 Airpark Dr., Redding, CA
- 3) 1036 Fifth Street, Eureka, CA
- 4) 495 Tesconi Circle, Santa Rosa, CA
- 5) 249-299 Nevada Street, Auburn, CA
- 6) 2760 Esplanade Ave, Suite 130, Chico, CA

Members: Cathryn Couch, Kim Tangermann, Nancy Starck, Dr. Phuong Luu, Alicia Hardy, Chris Champlin

Staff: Sonja Bjork (CEO), Danielle Ogren (Compliance Officer), Amy Turnipseed (Chief Strategy and Government Affairs Officer), Wendi Davis (COO), Jennifer Lopez (CFO)

Optional: Dr. Moore (CMO), Tina Buop (CIO), Kenzie Hanusiak (Associate Director of Regulatory Affairs & Compliance)

Topic	Notes
1) Call to Order	
2) ACTION: Approval of November 10, 2025 Minutes <i>Time: 5 minutes</i> <i>Speaker: Chair</i> <i>Page: 3-8</i>	
3) INFORMATION: Compliance, Privacy, and Fraud Officer Update <i>Time: 10 minutes</i> <i>Speaker: Danielle Ogren</i>	
4) DISCUSSION: FWA Provider Case Follow Up <i>Time: 10 minutes</i> <i>Speaker: Danielle Ogren</i>	
5) DISCUSSION: Program Integrity and FWA <i>Time: 15 minutes</i> <i>Speaker: Danielle Ogren/Kenzie Hanusiak</i>	
6) ACTION: Audits and Oversight Subcommittee Charter <i>Time: 5 minutes</i> <i>Speaker: Danielle Ogren</i> <i>Page: 9-12</i>	
7) INFORMATION: Security Officer Update <i>Time: 5 minutes</i> <i>Speaker: Andrew Timmins</i>	
8) ACTION: Review and Approve Compliance Program Dashboard and CAP Tracker Q4 <i>Time: 5 minutes</i> <i>Speaker: Danielle Ogren/ Kenzie Hanusiak</i> <i>Page: 13-15</i>	

**9) ACTION: Policies, All Plan Letters
(see separate packet)**

Time: 5 minutes

Speaker: Kenzie Hanusiak

MEETING AGENDA

Meeting: Governance / Compliance Committee

Date: November 10, 2025

Time: 1:00 PM -2:00 PM

Location: PHC Offices: **Partnership Offices**

- 1) 4665 Business Center Drive, Fairfield, CA (Board Room)
- 2) 2525 Airpark Dr., Redding, CA
- 3) 1036 Fifth Street, Eureka, CA
- 4) 495 Tesconi Circle, Santa Rosa, CA
- 5) 249-299 Nevada Street, Auburn, CA
- 6) 2760 Esplanade Ave, Suite 130, Chico, CA

Members Attended: Cathryn Couch, Kim Tangermann, Nancy Starck, Dr. Phuong Luu

Partnership Staff Attended: Sonja Bjork (CEO), Danielle Ogren (Senior Director of Regulatory Affairs), Kenzie Hanusiak (Sr. Manager of Regulatory Affairs & Compliance), Paige Smith (Program Coordinator II), Andrew Timmins (Sr. Director of Information Security), Leigha Andrews (Regional Director)

Topic	Notes
1) Call to Order	Called to order by Catherine Couch at 1:02pm
2) ACTION: Approval of September 15, 2025 Minutes <i>Speaker: Chair</i> <i>Page: 3-8</i>	Motioned by Nancy Starck to approve the Sept. 15th 2025 minutes and 2 nd by Kim Tandgermann. Motion passed.
3) ACTION: Resolution to approve of Alicia Hardy and Chris Champlin addition to the Governance & Compliance Committee	Introduced two additional GCC members: <ul style="list-style-type: none"> • Chris Champlin who has been on the board since 2024. • Alica Hardy who has been on the board for many years and was chairperson for 2 years. Neither were present at GCC Motioned by Catherine Couch to approve the addition of Chris Champlin and Alica Hardy to the Governance & Compliance Committee and 2 nd by Dr Luu. Motion passed.
4) INFORMATION: Compliance, Privacy, and Fraud Officer Update <i>Speaker: Danielle Ogren</i>	Compliance department has hired three new employees. Compliance Week was successful and included a month long “Caught You Being Compliance” (CYBC) department challenge. The month-long challenge was conducted similar

to our regular quarterly “walk-around” adults. Compliance department saw no change in results in this intensive CYBC challenge. We will be broadening our audits to add common spaces and adding “participation cards” to offices and cubicles after the individual audit is completed.

We have seen an increase in incident reported to compliance, which is expected after our event and launch of the annual training. We continue to promote our “no wrong door” approach.

Partnership is promoting the mindful use of AI and have hired an AI consultant to develop and provide an all staff AI training. As an organization, it’s important that we use AI safely while embracing technology. Noting, loading PHI into AI systems is a reportable incident.

Bills RAC is tracking

- AB 45: The collection, use, and disclosure of reproductive health data. However, this Bill is specific to research and we do not see direct impact to our Plan. We already have similar compliance requirements in effect for data we receive and transmit consistent with CMIA.
- SB 278: Is allowing the sharing of HIV data without patient consent. This one does have impact on the Plan as it authorizes providers to share personally identifiable HIV info with DHCS and the Plan the member is assigned to.

Hospice fraud is still a focus area for the DOJ and we continue to respond to requests for information.

We have joined a newly established CAHP workgroup to collaborate with other managed care plans regarding our approach to FWA.

The HCFS contract has been approved and is being executed. Compliance will work with IT on the implementation of this FWA data mining and case management software.

Catherine Couch remarked that she is excited to see what AI has to offer and the capabilities of it to enhance the work at partnership enterprise work.

Nancy Stark asked how many hospice facilities do we have and what is the impact? *Sonja Bjork, Chief Executive Officer*, replied that the DOJ investigation is a reaction to LA county’s increase in hospice fraud. Dr. Moore is really interested in the topic. We are looking at our policies to see where we can add clarity and infrastructure. APLs have helped tighten those gaps so

	<p>revisiting our policies is not that much of a burden.</p> <p><i>Mrs. Bjork</i> added that EHS has found a trend housing and food assistance fraud. Quality Incentive Program was developed to help support and gather data. CalAIM has created an awards incentive for on time and excellent data reporting. EHS implementing site visits for exact assurance.</p> <p><i>Dr. Luu</i>: does EHS have findings with the quality of the services provided or just the quantity?</p> <p><i>Mrs. Bjork</i> remarked that in the past, through similar programs, we have found that alcohol services and treatment were being billed but not provided.</p>
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<p>5) INFORMATION: Security Officer Update <i>Speaker: Andrew Timmins</i></p>	<p>Mandatory password changes resulted in a massive downward trend of duplicate and common passwords.</p> <p>Tested and deployed more in-house Network Detection and Response Tools to further strengthen our security posture. Will replace current solution, unify Endpoint Detection and Response with Network Detection and Response, creating a more unified single pane of glass for security personnel.</p> <p>A large-scale Security Assessment (Penetration Test) by third party scheduled for December 2025. It will focus on external security and social engineering.</p> <p>Partnership supports Community Based Organizations with a program to aid small entities that do not have their own security team. Smaller organizations may be more vulnerable to threat actors.</p> <p>Highlighting an attempted scheme where an IT member was targeted for gift card fraud. Where the scammers trick victims into purchasing gift cards and convincing them to share card numbers. Leading to financial gain for the scammers and financial loss for the victim. IT member was privy to the scam and was able to stop the scam before it was carried out.</p>
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**6) INFORMATION: Risk Assessment
Memo and Audit Calendar**
Speaker: Kenzie Hanusiak

Risk assessment takes into consideration the regulatory and enforcement priorities and trends, as well as an internal risk survey. This multi-faceted assessment offers a broad perspective and opportunities for auditing/monitoring. The volume of internal responses provides insight into enterprise trends and risk. A common theme among respondents is that regulatory complexity is putting a strain on human capital.

Mrs. Bjork added that EHS has found a trend housing and food assistance fraud. Quality Incentive Program was developed to help support and gather data. CalAIM has created an awards incentive for on time and excellent data reporting. EHS implementing site visits for exact assurance.

Audit calendar has 6 new audits with 10 carried over from the prior year. We're excited to have a new RAC team member Charlie Chaleunsky, *Reg. Affairs & Compliance Program Analyst*, who has 16 years with CMS. His unique experience will support our projected increase in regulator oversight.

Dr. Luu: posed a question regarding health care data sharing and how the plan is managing their responsibility? SB660 establishes the Center for Data Insights and Innovation, within the California Health and Human Services Agency. This will likely impact the Plan's interaction with the California Health and Human Services Data Exchange Framework. Dr. Luu will share a fact sheet for reference.

<p>7) INFORMATION: Annual Compliance Plan <i>Speaker: Dani Ogren</i></p>	<p>As a result of the new DHCS contract in 2024, we did an overhaul of our Compliance Plan. This year we further refined the Compliance Plan and examined how our structure aligns with that of other health plans compliance plans. As a result, we have removed the Risk Assessment Memo and Audit Calendar from the Compliance Plan. We have added Governance & Compliance Committee and adding training with LMS verbiage to the Compliance Plan.</p> <p><i>Ms. Stark</i> inquired as to why information was struck from page 42 specific to subcontractors. <i>Mrs. Hanusiak</i> advised that the information removed was duplicative information and assured the committee that the information were maintained in another section of the Compliance Plan.</p> <p>Motion by Kim Tangermann and 2nd Nancy Stark to approve the Compliance Plan as presented. Motion passed with no abstentions.</p>
<p>8) ACTION: Review and Approve Compliance Program Dashboard and CAP Tracker Q3 <i>Speaker: Danielle Ogren/Kenzie Hanusiak</i></p>	<p>Q3 Compliance Program dashboard is included in the packet for reference.</p> <p>Our Partnership annual training is at 96% completion, which includes staff on approved leave. We regularly send reminders to those who have not completed and work with HR as needed to ensue 100% completion.</p> <p>Timely report submissions are at 97% with one report granted an extension. Report rejection due to grammatical errors.</p> <p>Reportable HIPPA and fraud cases were reported timely 100% of the time.</p> <p>CAPS imposed by DHCS remain open although our proposed actions are approved.</p> <p>This includes CAPs for:</p> <ul style="list-style-type: none"> • Behavioral health focused audit (2023) • Network readiness – Member to provider ratios (geographic expansion) <p>6 Internal CAPs imposed by Compliance on internal departments – CAP status at various stages.</p> <p>Motion made Kim Tangermann and Catherine Couch 2nd. Motion passed without abstentions.</p>

<p>9) ACTION: Policies, All Plan Letters (see separate packet) <i>Speaker: Danielle Ogren</i></p>	<p>Policies changes include:</p> <ul style="list-style-type: none"> • CMP10 Confidentiality <ul style="list-style-type: none"> ○ Minor content changes • CMP18 Reporting Privacy Incidents <ul style="list-style-type: none"> ○ Reference list reviewed and updated
	<ul style="list-style-type: none"> ○ Phrasing changes for improved readability/clarity ○ Additional identifiers included to further specify data classified as PHI. ○ Notification procedures updated to specify the appropriate contact in the event of a privacy breach affecting more than 500 individuals <ul style="list-style-type: none"> • CMP26 Verification of Caller Identity and Release of Information <ul style="list-style-type: none"> ○ Immigration and Citizenship confidentiality provisions included where appropriate ○ Recordation/documentation requirements incorporated into procedural steps as required by law ○ Addition of a definition for Emancipated Minor in the Definitions section ○ Expansion of the Minor Consent Services definition to specify service types for minors under and over 12 years old <p>Motion by Nancy Stark and seconded by Dr. Luu. Motion passed without abstention.</p>
	<p>Cathryn Couch adjourned the meeting at 1:56 pm</p>

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Audits and Oversight Subcommittee Charter

LAST RATIFIED: _____, 2025

The Audits and Oversight Committee (AOC) is a subcommittee of the Compliance Committee and serves as the internal forum for Partnership HealthPlan of California's (Partnership) review of program integrity and oversight outcomes. The AOC is intended to strengthen Partnership's compliance posture and support prevention, detection, and recommended correction of program integrity risks including payment errors, process gaps, performance patterns and outliers, and other compliance breakdowns.

The AOC is intentionally structured as an internal venue where operational departments regularly report outcomes and observations (performance indicators, audit results, trends, root causes, and corrective actions) from self-directed program integrity activities. Additionally, it serves as a forum for Regulatory Affairs and Compliance (RAC) to present audit reports and corrective actions from internal auditing and monitoring. Together, bring awareness and opportunity for cross-functional leaders to make recommendations that harden controls, close gaps, and sustain audit readiness.

The AOC supports managed care requirements that plans implement and maintain structures to prevent and detect program integrity issues and operate a compliance program with governance oversight, monitoring/auditing, training, and reporting/referral mechanisms.

Regulatory and Contractual Basis

The AOC is established to ensure compliance with the following key requirements:

A. CMS Medicaid Managed Care Program Integrity

CMS requires Medicaid managed care organizations to implement and maintain administrative/management arrangements designed to detect and prevent issues that would jeopardize program integrity, including a compliance program with: written standards/policies, a compliance officer reporting to the CEO and board, and a Regulatory Compliance Committee comprised of Board members and at the senior management level to oversee the compliance program and compliance with contract requirements (Compliance Committee and Governance and Compliance Committee).

CMS also emphasizes that Compliance Committee role includes reviewing compliance/internal controls, monitoring/auditing work plans, ensuring training effectiveness, and ensuring corrective action plans are implemented and monitored for effectiveness.

The AOC is the Plan's management-level operational engine for audits/oversight that feeds into the Compliance Committee/Board's required oversight structure with regular reporting, escalations, and evidence.

B. DHCS Managed Care Program Integrity

DHCS requires Managed Care Plans (MCPs) to establish policies and procedures designed to prevent/detect FWA and to establish a Compliance program, a fraud prevention program, and other integrity processes meeting 42 CFR § 438.608.

DHCS further states MCPs may not delegate program integrity and compliance program functions to subcontractors/downstream subcontractors (though the Plan must ensure subcontractors/downstream have robust programs, which can be fulfilled by the MCP maintaining the functions on their behalf).

The AOC is the governance mechanism the Plan uses to demonstrate “robust” internal program integrity operations and ongoing performance monitoring with documentation and corrective actions aligned to DHCS expectations.

Committee Objectives

The AOC oversees enterprise program integrity and internal oversight across (at minimum):

1. **Maintain an internal oversight venue** where each operational department reports integrity-related outcomes, observations, and performance trends on a fixed cadence.
2. **Detect integrity risks early** through cross-functional review of outliers, repeat issues, and control breakdowns.
3. **Translate findings into action** by requiring root cause analysis (RCA), corrective action plans (CAPs), and effectiveness validation.
4. **Evidence compliance** with DHCS/CMS program integrity governance expectations via minutes, dashboards, work plans, and recommendations.
5. **Support required referral/reporting** pathways and timely response protocols as required by DHCS contract program integrity provisions.
6. **Reviews, monitors, and directs corrective action** for program integrity risks across various domains, which may include but is not limited to:
 - a. Encounter data integrity risks that materially impact capitation, reporting, or compliance exposure;
 - b. Controls supporting provider data integrity including credentialing, screenings, and ongoing monitoring of suspended/excluded/ineligible providers;
 - c. Utilization management integrity signals across various services; and
 - d. Grievance & Appeals trends that indicate systemic risk, Member Services complaint patterns, and provider complaints indicating potential billing/service anomalies.

AOC Authority:

- Require departments to submit metrics, audit results, and evidence on a defined cadence.
- Direct root cause analysis (RCA) and Corrective Action Plans (CAPs) with due dates and accountable owners.
- Escalate material risks to the Compliance Officer, CEO, and Compliance Committee, and/or Governance and Compliance Committee consistent with required governance oversight.
- Recommend policy changes, controls, training, or system edits to reduce recurrence of compliance and PI risks.

Corrective Action Governance (CAP Workflow)

In alignment with 42 CFR § 438.608 regarding expectation for routine monitoring/auditing and prompt corrective response, when issues are identified, the AOC will:

1. Assign an Owner and Due Date
2. Require RCA (Root Cause Analysis) (process, people, system, vendor/delegate)
3. Approve a CAP with measurable controls
4. Validate effectiveness (post-implementation monitoring)
5. Close only when evidence supports sustained remediation

**The AOC and/or Compliance Officer may elect to delegate the corrective action governance to RAC staff.*

Escalation Criteria

Immediate escalation to the Compliance Officer/Executive Leadership (and Compliance Committee and/or Governance and Compliance Committee, as appropriate) occurs when any of the following are present:

- Credible allegations or significant indicators of fraud requiring formal investigation and referral to applicable regulatory agencies;
- Systemic control failures with material financial/beneficiary impact;
- Repeated audit findings with missed CAP deadlines; or
- External audit demands requiring rapid response (Ex: DHCS or CMS)

Subcommittee Member Expectations:

- Subcommittee member or their proxy, shall be considered a subject matter expert (SME) in their respective area of focus, should be familiar with program requirements of the department/domain they represent and shall have the authority to act on behalf of their department to make recommendations for AOC activities, escalations, and/or corrective action.
- Responsible for facilitating action items and communicating pertinent information with their respective team members;
- Implements interventions and/or recommends corrective actions, as needed, when opportunities for improvement are identified; and
- Agrees to participate in active program integrity investigations, develop recommendations to determine outcome and corrective action plans when needed.

AOC Sub-Committee Members:

AOC Subcommittee shall be comprised of subject matter experts from each department and include the following or their designee:

- Sr. Director of Regulatory Affairs and Compliance (Compliance Officer)
- Associate Director of Regulatory Affairs and Compliance
- Manager of Regulatory Affairs
- Regulatory Affairs & Compliance Program Analyst
- RAC Program Manager II (Audits/Monitoring)
- Chief Health Services Officer
- Manager of Claims
- Director of Claims
- Director of Network Services
- Manager of Provider Relations Compliance
- Supervisor of Credentialing
- Director of Provider Relations
- Sr. Manager of Provider Relations Representatives
- Director of Care Coordination
- Sr. Director of Care Coordination
- Director of Human Resources
- Chief Financial Officer
- Director of Internal Audit, Finance
- Sr. Director of Member Services
- Director of Pharmacy Services
- Manager of Member Safety Quality Investigation
- Associate Director of Utilization Management Regulations
- Chief Information Officer
- Sr. Director of Information Security
- Director of Enhanced Health Services
- Manager of Enhanced Health Services
- Director of Utilization Management
- Director Grievance & Appeals
- Manager of Grievance & Appeals Compliance
- Director of Transportation Services
- Associate Director of Transportation
- Sr. Director Behavioral Health
- Director of OpEx/PMO
- Supervisor of Clinical Compliance

Governance

The AOC Subcommittee is a subcommittee of the Compliance Committee and is not subject to Brown Act requirements. AOC Subcommittee shall adhere to standard committee procedures. Specifically, a quorum is achieved when a majority of the members, or their designee, are present for a scheduled meeting. A motion may be made by any member. Motions are approved by a majority vote of the members present. A Regulatory Affairs and Compliance Department staff member will serve as Chair of the AOC Subcommittee.

Audits and Oversight Program Policies

- CMP02 – Risk Assessments, Audits, and Monitoring
- CMP07 – False Claims Act
- CMP27 – Non-Intimidation and Non-Retaliation
- CMP38 – Escalation and Corrective Action
- CMP45 – Administrative and Financial Sanctions
- FIN 405 – Treatment of Recoveries of Overpayments
- FIN 410 – Cost Avoidance and Post Payment Recoveries for Other Health Coverage

2025 Regulatory Affairs and Compliance Dashboard

Category	Description	Q1	Q2	Q3	Q4	YTD	Comments
DELEGATION OVERSIGHT	Annual Delegate / Subcontractor Audits	3 / 3	5 / 5	3 / 3	2 / 2	13 / 13	
When PHC delegates administrative functions that it is required by contract or regulation to perform, PHC retains the ultimate responsibility for the performance of these functions and must monitor and evaluate the performance of these functions when performed by a delegate.	Quarterly percentage to demonstrate the total number of annual delegate/subcontractor audits completed within 30 days following the planned months, as defined by the audit calendar.	100%	100%	100%	100%	100%	
	Oversight of Delegate Reporting	12 / 12	9 / 10	13 / 13	5 / 5	39 / 40	
	Percentage of timely submissions of regulatory reports.	100.0%	90.0%	100%	100%	97.5%	
TRAINING	Annual FWA Prevention Training	n/a	n/a	n/a	1653 / 1660	1653 / 1660	
	Percentage of employees that have completed the annual FWA training. <i>*Annual training released in Q4 2021*</i>	n/a	n/a	n/a	99.6%	96.3%	The total available staff for training was 1660 only 7 staff members missed the Q4 training deadline. RAC is working with HR for outstanding staff training
	Annual HIPAA Training	n/a	n/a	n/a	1653 / 1660	1653 / 1660	
	Percentage of employees that have completed the annual HIPAA training. <i>*Annual training released in Q3 2021*</i>	n/a	n/a	n/a	99.6%	96.3%	The total available staff for training was 1660 only 7 staff members missed the Q4 training deadline. RAC is working with HR for outstanding staff training
	Annual Code of Conduct	n/a	n/a	n/a	1654 / 1661	1654 / 1661	
	Percentage of completed annual Code of Conduct employee attestations.	n/a	n/a	n/a	99.6%	96.6%	The total available staff for training was 1661 only 7 staff members missed the Q4 training
REGULATORY REPORTING	DHCS Reports Submitted Timely	73 / 73	57 / 57	52 / 53	55 / 56	237 / 239	
Regulatory Affairs works collaboratively with all PHC departments to implement and track the timely submission of regulatory reporting requirements to PHC's governing agencies.	Percentage of regulatory reports submitted timely by RAC to DHCS with no missed due date per RAC Master Tracker and Regulatory Reporting Calendar.	100.0%	100%	98%	98%	99%	Q4-56 total reports submitted, all were submitted timely, one was returned for corrections.
	Report Acceptance Rate	72 / 73	55 / 57	52 / 53	55 / 56	234 / 239	
	Percentage of standard regulatory reports submitted by RAC and not rejected by DHCS for being incomplete, on the wrong template, or for other findings.	98.6%	96.5%	98%	98%	97.9%	Q4- 56 total reports submitted to DHCS. 55 were accepted. NMT-NEMT report was returned for a minor data correction.
HIPAA REFERRALS	Timely DHCS Privacy Notification Filings	10 / 10	11 / 11	14 / 14	17 / 17	52 / 52	
Appropriate safeguards, including administrative policies & procedures, to protect the confidentiality of PHI and ensure compliance with HIPAA regulatory requirements.	Percentage of reportable notifications that PHC filed timely within applicable DHCS required timeframe. <i>*Initial notice within 24 hours, initial PIR within 72 hours, and final PIR within 10 business days. If any deadline is missed, it will be counted as untimely.</i>	100.0%	100.0%	100.0%	100%	100.0%	Q4- 17 total reportable incidents submitted to DHCS all reported timely.
FWA REFERRALS	Timely DHCS FWA Notifications	9 / 9	23 / 23	39 / 39	36 / 36	107 / 107	
Regulatory Affairs oversees the Fraud, Waste and Abuse Prevention program intended to prevent, detect, investigate, report and resolve suspected and/or actual FWA in the PHC daily operations and interactions, whether internal or external.	Percentage of reportable notifications that PHC filed timely with DHCS within 10 business of discovery per contractual obligations.	100.0%	100%	100%	100%	100%	Q4-36 total reportable incidents all reported timely.

*Threshold percentages for the above measures are as follows:
 ≥ 95% = GREEN 90 - 94.9% = YELLOW < 90% = RED

CAP Tracker

*Please note that the above threshold percentages do not apply here

CAP Tracker

CAPS IMPOSED ON PARTNERSHIP BY REGULATORY BODIES				
CORRECTIVE ACTION PLANS (CAPS) CATEGORY	Description	Date of Imposition	Close Date	Comments
2024 Network readiness - member to provider ratios	<p>Failure to meet member to provider ratios in Butte, Humboldt, Lake, Nevada, Placer, Shasta, Sutter, Tehama, and Yuba counties.</p> <p>1. Non-compliant for failure to meet one FTE PCP per 2,000 Members in one or more of its service area(s)</p> <p>DHCS has mandated PHC compliance activities to include - must authorize out-of-network access irrespective of service or transportation cost; provide monthly status updates; receive DHCS approval of training and call scripts making members and providers aware of the CAP; submit a report of in-progress contracting to address deficiencies; and submit an analysis to determine the root cause of non-compliance.</p>	1/30/2024	TBD	<i>OPEN: Partnership retooled PCP reporting logic for the 274 to more accurately reflect member and provide geographic access. Revised logic reflected in the August submission of the July 274 data. Additionally, submitted a companion traceability file. Awaiting DHCS analysis of FTE compliance</i>
2023 Annual medical audit - focused audit; behavioral health	<p>2.1 - 2. 3 Care Management and Care Coordination</p> <p>The Plan did not ensure the provision of coordination of care to deliver mental health care services its members. Nor did the Plan follow up with members who did not receive referred treatments to understand barriers and make subsequent adjustments to referrals where warranted, including for SUD services</p> <p>The Plan is implementing various actions to address gaps in coordination between mental and physical health services. Key steps include policy updates addressing closed loop referrals, coordinating updates to the closed loop referral process with delegate, modifying the closed loop referral tracker, and on-going internal monitoring for process adherence</p>	8/30/2024	TBD	<i>ACCEPTED: DHCS has accepted the Plan's proposed corrective action and will monitor through closure Awaiting additional information on CAP closure</i>
2023 Annual medical audit - focused audit; behavioral health	<p>2.4 Plan MOU - policies/procedures</p> <p>The Plan did not comply with its Policies and procedures for the management of members care, including screening, assessment, care coordination, and the exchange of medical information. The Plan's MOU failed to address, screening, assessment, care coordination, and the exchange of medical information.</p> <p>The Plan is addressing gaps in executing MOUs and improving the monitoring of referrals by executing MOUs across all 24 counties per DHCS newly published template , modifying the closed loop referral tracker, and on-going internal monitoring for process adherence</p>	8/30/2024	TBD	<i>ACCEPTED: DHCS has accepted the Plan's proposed corrective action and will monitor through closure Awaiting additional information on CAP closure</i>
2023 Annual medical audit - focused audit; transportation	<p>3.1 - 3.3 NEMT—Provision of Door-to-Door Assistance</p> <p>The Plan did not have a process nor monitoring in place to ensure that door-to-door assistance was being provided for all members receiving NEMT services. Additionally, the Plan did not ensure that NEMT members do not miss their appointments if the NEMT provider is late or does not arrive at the scheduled pick-up time for the members.</p> <p>Partnership, is taking several actions to address gaps identified in the audit findings related to the Non-Emergency Medical Transportation (NEMT) program. This includes policy updates, updating member and provider materials regarding door-to-door assistance, implementing monitoring mechanisms to ensure the provision of this service, and monitoring grievance data to assess if failed rides contributed to missed appointments.</p>	8/30/2024	TBD	<i>ACCEPTED: DHCS has accepted the Plan's proposed corrective action and will monitor through closure Awaiting additional information on CAP closure</i>
2024 Annual Medical Audit	<p>4.1.1 Timely Resolution of Grievances - the Plan did not resolve quality of care grievances within 30 calendar days of receipt</p> <p>Partnership, is taking several actions to address gaps identified in the audit findings related to the Timely Resolution of Grievances. This includes revising and implementing policies and procedures to ensure QOC grievances are resolved within the required timeframes.</p>	4/11/2025	1/7/2026	CLOSED
2024 Annual Medical Audit	<p>5.1.1 Qualifications of Quality Improvement Staff - The Plan did not include the qualifications (education, experience, and training) of staff responsible for QI activities in the QI Program written description and QIHETP policies and procedures.</p> <p>Partnership, is taking several actions to address gaps identified in the audit findings related to the Qualifications of Quality Improvement Staff. This includes develop and implement policies and procedures to ensure the qualifications of staff responsible for QI activities are included in the QI Program written description and QIHETP policies and procedures.</p>	4/11/2025	1/7/2026	CLOSED
2023-2024 DHCS DMC-ODS Network Adequacy Monitoring	<p>In follow-up to Partnership presentation of proposed corrective action to address network adequacy deficiencies identified during the Fiscal Year (FY) 2023-2024, DHCS is conducting assessment of on-going compliance. DHCS found that the Plan did not meet time or distance adequacy standards for outpatient services for opioid treatment providers for both children and adults and deficient in adequacy for intensive outpatient treatment for children and youth and residential providers for adults.</p> <p>Plan is responsible for describing how to address these network gaps and provide supporting evidence to ensure compliance</p>	9/18/2025	TBD	<i>OPEN: Partnership has been submitted responses and pending DHCS response</i>

CAP Tracker

CAPS IMPOSED ON INTERNAL PARTNERSHIP BUSINESS UNITS				
CORRECTIVE ACTION PLANS (CAPS) CATEGORY	Description	Date of Imposition	Close Date	Comments
2024 Transportation Internal Audit	As a result of a provider grievance, Compliance conducted an internal audit to assess Partnership's documented process for the transportation program and the provider grievance process. As a result of the internal audit, Compliance has issued a CAP to address the process for vetting and credentialing transportation providers, member assignment, monitoring provider performance, and transportation grievance process.	11/7/2024	1/5/2026	CLOSED
2024 COVID-19 Sunset Audit	As part of the planned audit calendar, Compliance conducted an internal audit to evaluate the effective execution of the DHCS COVID-19 sunset guide. As a result of the internal audit, Compliance confirmed successful implementation of the sunset plan. However, identified a gap in the cross-departmental communication (closed loop communication) regarding coding and configuration changes that impact departments including UM, Claims, and Configuration.	1/30/2025	TBD	<i>OPEN: All CAPs are closed with the exception open CAPs for Configuration. Compliance will continue to work with the department until all CAPs are closed. 0 CAPs closed since last update. 2 of 2 CAPs remain open.</i>
2024 Business Associate Agreement Internal Audit	As part of the planned audit calendar, Compliance conducted an internal audit to evaluate the effectiveness of Partnership's documented process for establishing and maintaining adherence to Business Associate Agreements (BAAs) with contractors and subcontractors. As a result of the internal audit, Compliance identified gaps in the business rules around BAA's including the roles and responsibilities of all involved parties to ensure comprehensive and consistent oversight of BAA's throughout it's lifecycle. Compliance has issued a CAP to address gaps surrounding BAA implementation and oversight.	2/20/2025	TBD	<i>OPEN: Compliance is awaiting dept. responses. Compliance will continue to work with dept. to move CAPs to closure. 0 CAPs closed since last update. 1 of 1 CAPs remain open.</i>
2024 Provider Training Program Internal Audit	As part of the planned audit calendar, Compliance conducted an internal audit to assess Partnership's program and materials for training providers and subcontractors consistent with regulatory requirements of frequency, topics, and reporting. As a result of the internal audit, Compliance has issued a CAP to address oversight of the provider training program including the creation and execution of the training calendar, process for addressing provider non-compliance, and ensuring training content alignment with regulatory information.	1/14/2026	TBD	<i>OPEN: Compliance is awaiting dept. responses. Compliance will continue to work with dept. to move CAPs to closure. 0 CAPs closed since last update. 5 of 5 CAPs remain open.</i>