Policy and Procedure No: CO 8.4	**Revision No: 4**
Division: Managed Care Division	
Department: Compliance	
Title: PHC-CA Responses to Detected Offenses and CAPS	
Effective Date: 1/1/2006	
Supersedes Policy No: 97008, CO 8.0, CO 8.1, CO 8.2, CO 8.3	
Reviewed/Revised by: Sandra Holzner	**Review/Revision Date: 12/14/2025**
Approving Committee: Compliance Committee	**Date: 12/15/2025**
Executive Oversight Committee Date: 12/16/2025	

Purpose:

The purpose of this policy is to outline the Health Plan's commitment to promptly responding to any detected instances of fraud, waste, and abuse (FWA) and any identified non-compliance with contractual, regulatory, or internal policy requirements. This includes initiating timely investigations, implementing corrective action initiatives to address root causes, and ensuring preventive measures are in place to mitigate future occurrences. The Health Plan will escalate significant or persistent non-compliance to the Compliance Officer, the Managed Care Compliance Committee, the Executive Oversight Committee of the Board of Directors (EOC) and when required, report such matters to the Department of Health Care Services (DHCS) in accordance with Medi-Cal Managed Care Contract provisions.

Policy:

1. The Health Plan must develop and maintain effective systems for prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Contract (42 CFR section 438.608(a)).

    a. This includes policies and procedures for constructing and implementing effective Corrective Action plans, including root cause analysis and tailoring Corrective Action plans to address specific compliance concerns;

    b. Corrective action plans must be reviewed and signed by the Compliance Officer and the executive officer responsible for the area subject to the Corrective Action Plan.

        i. To demonstrate effective systems to address compliance concerns and implement effective corrective action, Contractor must maintain and publicly post records of Corrective Action plans and the rectifying actions to close out the findings, including but not limited to, committee meeting minutes detailing discussion of corrective action plans and description of outcomes; and

    c. The Health Plan must ensure contractual provisions are in place through subcontractor Agreements and Downstream Subcontractor Agreements, as relevant, to enforce compliance with Corrective Action plans when they are not met, such as financial sanctions, payment withholds, or liquidated damages.

Procedure:

Corrective Action Plans

1. When the Compliance Officer receives a report of suspected noncompliance, the Compliance Officer and/or designee will initiate a prompt inquiry.

2. If the Compliance Officer determines that conduct may involve potential fraud, waste, abuse (FWA) or other illegal activity, the Compliance Officer shall immediately notify the Health Plan's Legal Department and, under Legal's direction, initiate a prompt and thorough investigation. Likewise, if any employee, agent, or contractor reports suspected illegal conduct—including, but not limited to, misconduct related to payment or delivery of items or services, the Compliance Officer will report the matter to Legal and follow Legal's guidance regarding investigative steps and resolution.

3. If the Compliance Officer's investigation discloses noncompliance with any legal or contractual requirement, the Compliance Officer will recommend to the Care Management Compliance Committee an appropriate corrective action (for example, repayment of overpayments disciplinary actions against responsible employees). In the event the investigation discloses misconduct by an employee, the Compliance Officer shall notify the employee's supervisor and Human Resources Department to take appropriate disciplinary action. In the event the investigation discloses misconduct by an agent or subcontractor, the Compliance Officer shall recommend to the Care Management Compliance Committee that it initiate disciplinary action up to including contract termination.

4. Corrective action plans will be designed to correct the underlying problem that results in program violations and prevent future misconduct. See Attachment A: Sample Template Corrective Action Plan.

    a. When a compliance finding, audit result, or performance issue is identified, the Care Management Department responsible must first clearly define the nature of the issue.

        i. This includes documenting the specific policy, regulation, or contractual requirement that was not met, as well as the date, circumstances, and scope of the issue.

        ii. The Department should also describe the potential impact of the findings, whether operational, financial, provider-related, or member-related.

        iii. All identified issues must be communicated to the Compliance Department.

    b. Next, the department must conduct a Root Cause Analysis (RCA) to determine the underlying factors that contributed to the issue. The goal of this analysis is to identify why the problem occurred rather than focusing solely on the immediate error. Various methods may be used, including the "Five Whys" technique, which involves repeatedly asking "why" until the fundamental cause is identified; the Fishbone (Ishikawa) diagram, which categorizes possible causes into people, process, policy, systems, and environment; or process mapping to pinpoint where operational breakdowns occur. The RCA should distinguish between systemic causes, such as insufficient training, unclear procedures, or gaps in oversight, and isolated individual performance issues. The results of the analysis must be documented in writing and included as part of the CAP submission.

c. Based on the findings of the root cause analysis, the department will then develop a Corrective Action Plan that outlines the specific steps needed to resolve the issue. Each CAP must include a clear description of the corrective actions to be taken, the responsible individuals or departments, timeframes for completion, evidence that will demonstrate the action was implemented, and a plan for monitoring continued compliance. The completed CAP should be submitted to the Compliance Department for review and formal approval prior to implementation to ensure that the proposed actions adequately address the identified issue and regulatory requirements.

d. Once approved, the Department is responsible for implementing the CAP as written and for providing regular progress updates to Compliance. Compliance may request supporting documentation, such as updated policies and procedures, training materials, communication logs, or audit data to verify progress.

e. After all corrective actions have been implemented, the department must provide evidence to Compliance demonstrating that the plan has been fully executed and that the corrective measures are effective in preventing recurrence.

5. The Compliance Officer shall report Corrective Actions to the Care Management Compliance Committee and the EOC at least four (4) times per year.

6. The Compliance Officer will report instances of FWA or unlawful conduct to outside government agencies as specified below.

Reporting Suspected Fraud, Waste, Abuse (FWA) to DHCS

1. All staff shall immediately report cases of suspected Medi-Cal fraud and/or abuse by subcontractors (especially by any pharmacy benefits manager), members, providers, or employees to their supervisor, who shall report to the Compliance Officer for immediate reporting to the Chief of Managed Care and the Director of Compliance. Staff may also use the Compliance hotline (1-800-243-7448 or 1-800-AIDSHIV) if they wish to report anonymously.

2. The Compliance Department will provide periodic employee training, at least annually, on what constitutes Medi-Cal fraud and abuse, and how to report it.

3. The Compliance Officer will review reports of fraud and/or abuse and, where the Officer determines that there is reason to believe that an incident of Medi-Cal fraud and/or abuse has occurred, the Compliance Officer, upon consultation with the Chief of Care Management and the Compliance Director, will notify the Contracting Officer and Program Integrity Unit at DHCS within ten (10) state working days of the date when the Director first became aware of or was on notice of such activity.

4. The Compliance Officer will comply with all applicable federal policies concerning the use and disclosure of PHI when reporting to DHCS.

5. When reporting to DHCS, the Compliance Officer should complete and report to DHCS the results of the Director's preliminary investigation of the suspected fraud and/or abuse on a Confidential Medi-Cal Complaint Report (MC 609) that can be sent to DHCS in one of three ways:

   (a) Email at PIUCases@DHCS.ca.gov

(b) E-fax at (916) 440-5287

(c) U.S. mail at:

Department of Health Care Services
Medi-Cal Managed Care Division
Attention: Chief, Program Integrity Unit
P.O. Box 997413, Mail Stop 4411
Sacramento, CA 95899-7413

6. As many of the following support documents as possible should be submitted with the MC 609 form:

   a. Police report

   b. Health Plan's documentation

   c. Background information

   d. Investigation report

   e. Interviews

   f. Any additional investigative information

   g. Member information

   h. Patient history chart

   i. Patient profile

   j. Claims detail report

   k. Provider enrollment data

   l. Confirmation of services

   m. List of items or services furnished by the provider

   n. Pharmaceutical data from manufacturers, wholesalers and retailers

   o. Any other pertinent information.

7. Upon determining that there is reason to believe that an incident of fraud and/or abuse has occurred, the Compliance Officer shall notify DHCS prior to conducting any further investigation. At the request of DHCS, the Director shall consult with DHCS prior to investigating.

8. The Compliance Officer or designee reports investigation results within ten (10) state working days of conclusion of any fraud and/or abuse investigation.

9. The Compliance Officer or designee will notify, as appropriate, Health Plan staff/departments of

pending/completed investigations and provide:

a. Instructions for dealing with the provider during the investigation, e.g., no referrals, no new members, etc.

b. Instructions for dealing with the provider after the investigation (remove members, remove active status)

c. In cases involving employees, refer to Human Resources to determine appropriate corrective and/or disciplinary actions

d. In cases involving members, refer to Legal and/or Member Services to determine appropriate corrective actions

Definitions:

1. Abuse: means practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program.

2. AHF refers to AIDS Healthcare Foundation and its affiliates/subsidiaries who offer managed care health plans.

3. Corrective action is the response of the Health Plan to potential violations relating to misconduct and/or noncompliance.

4. Fraud: means an intentional deception or misrepresentation made by persons with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person and includes any act that constitutes Fraud under applicable federal or State law, including 42 CFR section 455.2 and W&I section 14043.1(i).

5. Misconduct is a potential instance of fraud, waste and abuse relating to the Health Plan's participation in the Medi-Cal program.

6. Waste: means the overutilization or inappropriate utilization of services and misuse of resources.

Monitoring:

This policy is updated, as necessary, reviewed and approved annually by the Managed Care Compliance Committee.

Reference(s):

DHCS Managed Care Contract

Regulatory Agency Approval(s):

Date	Version	Regulatory Agency	Purpose	Response

Pending	8.3	Department of Managed Health Care	Filing No. 20240216	Pending

Attachment A

AHF
AIDS HEALTHCARE FOUNDATION

Corrective Action Plan

Date:	[Date that the CAP is written]
To:	[Name]
From:	[Name, title, and the site or institutional affiliation of the person authoring the CAPA, and this individual's signature]
Operational Area:	[Claims, Utilization Management, Claims etc.]
Line of Business	[Ryan White, PHP, PHC California]
Issue:	[Brief description or outline of the topic/process/problem being documented; can be formatted as a paragraph, numbered list, or bulleted items]
Root Cause:	[The reason(s) that the issue arose]
Corrective Action Plan:	[Description of the corrective actions taken or planned by the site personnel. If the site was instructed to perform these corrective actions indicate by whom and as of what date.
Implementation:	[Description of the procedures used to document resolution of the problem, the personnel who are responsible for the procedures etc.]
CAP Close Date	Click here to enter text.

PHC CALIFORNIA

Evaluation / Follow-up:	[Any plan / procedure to evaluate the implementation and completion, personnel who are responsible for the evaluations, timeframe for the evaluation, etc.]
Comments:	[Any additional comments or information not noted above]

Approved by [Name and Title]	Date of Signature
Compliance Officer Printed Name	Date of Signature