Health Plan of San Mateo
Policy & Procedure Manual

Procedure: CP.008		Title: Internal Auditing	Original Effective Date: 09/04/2015
Revision: 8	Last Reviewed /Revised: 05/21/2024	Dept: Compliance	Page 1 of 5

Approval By: Compliance Committee	**Date:** 11/09/2024
Annual Review Date: 06/01/2025	
Authored by: Government and Regulatory Affairs Manager	
Pursuant To: ☒ DHCS Contract Provision Exhibit A, Attachment III, Provision 1.3.1(K) ☐ Health and Safety (H&S) Code ☒ CFR 42 CFR 422.503(b)(4)(vi)(F); 423.504(b)(4)(vi)(F); 438.608(a)(1)(vii) ☐ APL / DPL	☐ W & I Code ☐ California Title # ☐ Organization Need ☒ Other: Medicare Managed Care Manual Chapter 21, Section 50.6.1; Medicare Prescription Drug Benefit Manual Chapter 9, Section 50.6.1
Departments Impacted: All	

Policy:

To document HPSM's overall policy and procedure for the Internal Auditing program.

Scope

This procedure applies to (check all that apply):

☒ All LOBs/Entire Organization	☐ CCS	☐ Medi-Cal Expansion
		☐ Medi-Cal Adults
☐ ACE	☐ HealthWorx	☐ Medi-Cal Children
☐ CA-DSNP	☐ Medi-Cal	☐ Other (specify)

Responsibility and Authority

- The Chief Government Affairs and Compliance Officer is responsible for overseeing compliance with the procedures outlined below.
- The Director of Compliance is responsible for the internal audit program and its performance.
- Directors and Managers are responsible for the dissemination and application of this policy in their departments.
- The Director of Compliance and Internal Audit personnel have the authority for unfettered access to all pertinent compliance information such as data, records, and personnel.

Procedure: CP.008		Title: Internal Auditing	Original Effective Date: 09/04/2015
Revision: 8	Last Reviewed /Revised: 05/21/2024	Dept: Compliance	Page 2 of 5

Definitions

Audit is a formal review of compliance with a particular set of internal (e.g., policies and procedures) or external (e.g., laws and regulations) standards used as base measures, and are performed by someone with no vested interest in the outcomes or business area being reviewed.

Corrective Action Plan (CAP) is a description of the actions to be taken to correct identified deficiencies and to ensure future compliance with the applicable requirements. A CAP usually contains accountabilities and set timeframes.

Dashboard is an auto-generated report of various compliance measures from across HPSM departments. The dashboard will be run from data on various platforms, such as HEALTHsuite and MedHOK. This report will be accessible by department managers and key staff in the Compliance department who will actively monitor compliance with regulatory benchmarks and will have the authority to trigger ad hoc audits of non-compliant departments and/or issue CAPs. The dashboard is a vital tool in effectively monitoring department compliance with regulatory requirements.

Deficiency is an instance of non-compliance identified through internal audit and/or other monitoring efforts.

Internal Audit Team is a group of HPSM staff within the Compliance Department that provides independent, objective, and comprehensive reviews designed to evaluate and assess the adequacy and effectiveness of various areas of the company.

Monitoring includes surveillance activities conducted during the normal course of operations and which may not necessarily be independent of the business area being monitored (e.g., self-reviews, peer reviews, etc.). Monitoring activities may occur to ensure corrective actions are being implemented and maintained effectively or when no specific problems have been identified to confirm ongoing compliance.

Risk Assessment is the identification, measurement, and prioritization of likely relevant events or risks that may have material consequences on HPSM's ability to maintain compliance with program requirements.

Procedure

1.0 Risk Identification

1.1 The Compliance Department identifies compliance risks to HPSM by reviewing, at a minimum:

Procedure: CP.008		Title: Internal Auditing	Original Effective Date: 09/04/2015
Revision: 8	Last Reviewed /Revised: 05/21/2024	Dept: Compliance	Page 3 of 5

1.1.1 CMS, DHCS, and DMHC guidance relating to regulatory risks

1.1.2 NCQA standards and survey results

1.1.3 The OIG work plan

1.1.4 Audit findings from external reviewers (e.g., CMS, OIG, DMHC, etc.)

1.1.5 Enforcement notices from state or federal regulatory agencies

1.1.6 Audit and monitoring findings from internal reviewers (e.g., departments; Internal Audit)

1.1.7 Internal operational dashboards, metrics and/or scorecards

1.1.8 Member "touch points" such as Grievances & Appeals, Claims, Member Services, CareAdvantage Unit, Sales, Marketing

1.1.9 Self-identified issues reported by the business units

1.1.10 New regulatory requirements

1.1.11 New operational systems or practices

1.1.12 CAPs from previous audits

2.0 Internal Audit Plan Development

2.1 The Compliance Department creates an annual audit plan based on the sources listed above, as well as with input from the departments.

2.2 The order of the sources listed above does not reflect weighting, and items on the audit plan will be given priority through input from the Chief Government Affairs and Compliance Officer, Director of Compliance, Compliance Committee and/or San Mateo Health Commission based on member impact, financial impact, or reputational impact.

2.3 The audit plan lists the department and area to be audited. Objectives for each audit may be found in each audit's protocols. FDR and delegate audits are also specified.

2.4 The audit plan is subject to change due to staffing concerns, competing priorities from external audits, or other activities. Additionally, the frequency of some audits may be decreased or increased based on the results of prior audits.

2.5 Once the draft audit plan is created, it is provided to the Compliance Committee for their review and approval.

2.6 Any changes to the audit plan are provided to the Compliance Committee on a quarterly basis.

3.0 Internal Audit Process

Procedure: CP.008		Title: Internal Auditing	Original Effective Date: 09/04/2015
Revision: 8	Last Reviewed /Revised: 05/21/2024	Dept: Compliance	Page 4 of 5

3.1 The Internal Audit team in the Compliance Department will be responsible for communicating with the audited area.

3.2 The auditor assigned to the audit will utilize provided audit tools that will contain all the data points needed to successfully complete the audit fieldwork.

3.3 Auditors will request necessary data from the audited operational team to perform the audit.

3.4 Using appropriate regulatory guidance and internal policies and procedures, the auditor will conduct the audit.

3.5 If discussions need to take place for the auditor to ask questions from the department involved, the auditor will attempt to minimize the number of separate meetings to limit disruption of the department's daily tasks.

3.6 Upon conclusion of the audit fieldwork, the auditor will write a draft audit report outlining in an executive summary the objectives, approach, validated findings, and recommendations that the Compliance Department has for the department audited, as well as whether a CAP is required because of the audit findings.

3.7 Any findings identified during the audit will be explained and will be noted as a repeat finding if the same finding was identified in the preceding audit.

3.8 Audit reports may include observations noted during the audit that either do not rise to the level of a finding.

4.0 Audit Report Review

4.1

4.2 The Government and Regulatory Affairs Manager is responsible for reviewing audit reports and working with the auditor involved to improve the content of the report.

4.3 Upon approval by the Government and Regulatory Affairs Manager, the audit report and any tools used in fieldwork will be shared with the business owner of the audited area.

5.0 Audit Exit Conference

5.1 No less than two weeks after the audit report and tools have been shared with the business owner, an exit meeting will be scheduled so that the Compliance staff involved in the audit can discuss the audit with the audited department.

5.2 It is expected that the audited department will come to the exit meeting prepared to dispute findings in the draft report, ask clarifying questions regarding the findings or observations, and/or brainstorm on possible root causes and corrective actions.

5.3 An exit conference may not be scheduled if the audit yielded no findings. In that case, the audit report and tools will still be shared with the business owner.

Procedure: CP.008		Title: Internal Auditing	Original Effective Date: 09/04/2015
Revision: 8	Last Reviewed /Revised: 05/21/2024	Dept: Compliance	Page 5 of 5

6.0 Corrective Action Plans (CAP)

6.1 Corrective action plans (CAP) will be issued for deficiency identified per CP.027 Corrective Action Plan Process.

Related Documentation

- CP.000 Compliance Program
- CP.011 Risk Assessment Development Process
- CP.027 Corrective Action Plan Process

Attachments

- Internal Audit Report Template
- Internal Audit CAP Template

Log of Revisions	
Revision Number	Revision Date
0	09/04/2015
1	09/01/2016
2	09/28/2016
3	02/24/2017
4	03/16/2017
5	03/07/2018
6	03/04/2019
7	07/12/2021
8	05/21/2024