



Bureau of Fee-For-Service Programs
Statement of Findings / Corrective Action Plan

MA /Provider Number: 0000000000 Provider Agency: ABC Address: 123 Street Zip 12345 Provider Contact: Name E-mail Address: (name@url.com)	QMET Program Specialist: First Last Contact Information: XX QMET Forum Place 6th Floor P.O. Box 8025 Harrisburg, PA 17105-8025 M (717) xxx-xxxx (your email)@pa.gov	Monitoring Date(s): Month xx, xxxx SoF email Date:
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Background:

A Regulatory Monitoring performed by the Quality Management Efficiency Team (QMET) on *(insert date)*, identified areas of non-compliance with 55 Pa. Code Chapters 52, 1101 and/or 1150. These areas of non-compliance with the regulations are listed as findings in the Statement of Findings (SoF) section of this document beginning on page 4.

According to 55 Pa. Code § 52.23 (a)-(b) (relating to corrective action plan), the submission of a Corrective Action Plan (CAP) is required of your agency to correct the identified areas of non-compliance. You are required to complete the Corrective Action Plan section of this document beginning on page 4.

The Regulatory Monitoring Claims Review resulted in No Overpaid Claims Overpaid Claims

If there were Overpaid Claims, a PROMISe Claims Review Form is included with this email. 55 Pa. Code § 52.42(c) and (d) state that “The Department will only pay for a service in accordance with this chapter and Chapters 1101 and 1150 (relating to general provisions; and MA Program payment policies) and “The Department will only pay for a service in the type, scope, amount, duration and frequency as specified on the participant’s service plan as approved by the Department”. Furthermore, 55 Pa. Code § 52.51(a) “The Department will only pay for the actual cost of a vendor good or service which may not exceed the amount for similar vendor good or service charged to the general public.” Therefore, according to 55 Pa. Code § 52.42(f) “The Department will recoup payments not made in accordance with this chapter.” The Bureau of Fee-For-Service Programs will be in contact with your agency regarding recoupment procedures. If you agree with these findings, you may adjust your claims prior to the Bureau of Fee-For-Service Programs contact.

Instructions for completion of CAP:

The CAP documents steps performed by your agency to become compliant with the regulations. QMET determined that your agency is non-compliant with one or more regulations as identified in the SOF. As a result, you are required to complete the CAP and return the revised Microsoft Word document as an email attachment to *(insert PS name & email address)* no later than *(insert date-15 business days from the date of this email)*. The Office of Long-Term Living will review the completed CAP for approval. It is essential that you complete this CAP in sufficient detail to address all areas of non-compliance completely. **Please DO NOT include attachments with your CAP.** Upon approval of your CAP, the QMET will notify you when it is appropriate to send in verification of compliance with your CAP (and thus the regulations). **Failure to return an adequate and timely CAP may result in the Office of Long-Term Living taking further action as listed in 55 Pa. Code § 52.64 (relating to payment sanctions and possible termination from the program).** Please provide your authorization of the Corrective Action Plan by signing and dating the last page of this document. Contact *(insert PS name)* to address any questions or concerns that you may encounter when completing this plan.

Statement of Findings / Corrective Action Plan

Complete all sections of the CAP (see explanations on page 3) as follows:

1. **“Action Steps to Correct Finding”**: This column represents detailed actions performed or to be performed to correct the findings; **OR** a statement, as appropriate, which describes the reason(s) that corrective action cannot be completed or is unnecessary.
2. **“Steps to Prevent Future System Reoccurrences”**: This column represents how your agency will modify internal practices/systems to prevent reoccurrence of the finding.
3. **“Agency Responsible Person(s) with Title”**: This column represents the name and title of the agency staff person responsible for ensuring the proposed actions are complete.
4. **“Date for Complete Remediation”**: This column represents the specific date (mm/dd/yy) for completion of all action steps.
5. **“Agency Internal Quality Management”**: This column represents how your agency will monitor ongoing effectiveness of CAP practices/systems.

Complete the Signature Page as follows:

1. Enter all required information, sign and date
2. Scan the Signature Page
3. **Include the scanned Signature Page as an attachment to the email when submitting the CAP.**



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Statement of Findings

MA /Provider Number: 0000000000 Provider Agency: ABC Address: 123 street Zip 12345		QMET Program Specialist: First Last Contact Information: (your email)@pa.gov	Monitoring Date(s): Month xx, xxxx
Regulation	55 Pa. Code §52 will be stated in this box.		
Finding #	<i>An explanation of what QMET found is stated in this box. The provider's corrective action plan needs to address and correct everything stated in this finding to be compliant with the Regulation.</i>		

Corrective Action Plan as per 55 Pa. Code § 52.23(c)

Action Steps to Correct Each Finding(s)	Action Steps to Prevent Future System Reoccurrences	Agency Responsible Persons with Title	Date for Complete Remediation	Agency Internal Quality Management
DIRECTIONS: This column represents actions performed or to be performed to correct the findings; OR a statement, as appropriate which describes the reason(s) that corrective action cannot be completed or is unnecessary. *WHAT QMET LOOKS FOR: <i>* Are the corrective action steps addressed in sufficient detail to indicate a thoughtful and well-planned response to correct each finding?</i>	DIRECTIONS: This column represents how your agency will modify internal practices/systems to prevent reoccurrence of the finding. *WHAT QMET LOOKS FOR: <i>*If training is a component of the CAP, is there sufficient detail present to indicate that the provider has planned for the development and implementation of the training?</i>	DIRECTIONS: This column represents the name and title of the agency staff person responsible for ensuring the proposed actions are complete. *WHAT QMET LOOKS FOR: <i>* Are the timeframes reasonable for each corrective action?</i>	DIRECTIONS: This column represents the specific date (mm/dd/yy) for completion of all action steps. *WHAT QMET LOOKS FOR: <i>* Are the timeframes reasonable for each corrective action?</i>	DIRECTIONS: This column represents how your agency will monitor ongoing effectiveness of CAP practices/systems. *WHAT QMET LOOKS FOR: <i>* Does the internal quality management system adequately address how the provider will monitor ongoing effectiveness of CAP practices/systems?</i>

QMET Staff Person and Date of CAP Monitoring:

Verification of Incomplete/Complete CAP:

QMET Program Specialist _____ Date Approved _____



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Provider Agency: ABC	Contact Information: (your email)@pa.gov	
Address: 123 Street Zip 12345		

Regulation	
Finding #	

Corrective Action Plan as per 55 Pa. Code § 52.23(c).

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Corrective Action Plan as per 55 Pa. Code § 52.23(c) Signature Page

Monitoring Date(s):	Month xx, xxxx
Agency Name - Provider Number:	ABC- 0000000000
Printed Name:	
Title:	
Email Address:	
Authorized Signature:	
Date:	

The signature above indicates that I have reviewed and authorized the provisions outlined in the Corrective Action Plan.