CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

April 19, 2024

Jane MacAdam, Director of Compliance *Via E-mail*
Deborah Murr, Chief Compliance and Fraud Prevention Officer
Kern Family Health Care
2900 Buck Owens Boulevard
Bakersfield, CA 93308

RE: Department of Health Care Services Medical Audit

Dear Ms. MacAdam and Ms. Burr:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Kern Family Health Care, a Managed Care Plan (MCP), from November 28, 2022 through December 9, 2022. The audit covered the period from November 1, 2021, through October 31, 2022.

The items were evaluated, and DHCS accepted the MCP's submitted Corrective Action Plan (CAP). The CAP is hereby closed. The enclosed documents will serve as DHCS' final response to the MCP's CAP. Closure of this CAP does not halt any other processes in place between DHCS and the MCP regarding the deficiencies in the audit report or elsewhere, nor does it preclude the DHCS from taking additional actions it deems necessary regarding these deficiencies.

Please be advised that in accordance with Health & Safety Code Section 1380(h) and the Public Records Act, the final audit report and final CAP remediation document (final Attachment A) will be made available on the DHCS website and to the public upon request.

If you have any questions, please reach out to CAP Compliance personnel.

Sincerely,

[Signature on file]
Lyubov Poonka, Chief
Audit Monitoring Unit
Process Compliance Section
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

Enclosures: Attachment A (CAP Response Form)

cc: Stacy Nguyen, Chief *Via E-mail*
Managed Care Monitoring Branch
Managed Care Quality and Monitoring Division
Department of Health Care Services

Maria Angel, Lead Analyst *Via E-mail*
Audit Monitoring Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

Lucas Patton, Contract Manager *Via E-mail*
Medi-Cal Managed Care Division
Department of Health Care Services

ATTACHMENT A

Corrective Action Plan Response Form

Plan: Kern Family Health Care

Review Period: 11/01/21 – 10/31/22

Audit: Medical Audit and State Supported Services

On-site Review: 11/28/22 – 12/09/22

MCPs are required to provide a Corrective Action Plan (CAP) and respond to all documented deficiencies included in the medical audit report within 30 calendar days unless an alternative timeframe is indicated in the CAP Request letter. MCPs are required to submit the CAP in Word format, which will reduce the turnaround time for DHCS to complete its review. According to ADA requirements, the document should be at least 12 pt.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, as well as the operational results of that action. The MCP shall directly address each deficiency component by completing the following columns provided for MCP response: 1. Finding Number and Summary, 2. Action Taken, 3. Supporting Documentation, and 4. Completion/Expected Completion Date. The MCP must include a project timeline with milestones in a separate document for each finding. Supporting documentation should accompany each Action Taken. If supporting documentation is missing, the MCP submission will not be accepted. For policies and other documentation that have been revised, please highlight the new relevant text and include additional details, such as the title of the document, page number, revision date, etc., in the column "Supporting Documentation" to assist DHCS in identifying any updates that were made by the plan. Implementing deficiencies requiring short-term corrective action should be completed within 30 calendar days. For deficiencies that may be reasonably determined to require long-term corrective action for a period longer than 30 days to remedy or operationalize completely, the MCP is to indicate that it has initiated remedial action and is on the way toward achieving an acceptable level of compliance. In those instances, the MCP must include the date when full compliance will be completed in addition to the above steps. Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval, as applicable, according to existing requirements.

Please note that DHCS expects the plan to take swift action to implement improvement interventions as proposed in the CAP; therefore, DHCS encourages all remediation efforts to be in place no later than month 6 of the CAP unless DHCS grants prior approval for an extended implementation effort.

DHCS will communicate closely with the MCP throughout the CAP process and provide technical assistance to confirm that the MCP offers sufficient documentation to correct deficiencies. Depending on the number and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates.

1. Utilization Management

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
1.3.1 State Fair Hearing Request The Plan did not comply with existing APLs to notify members receiving a NAR, that upholds an adverse benefit determination, that they have an additional 120 days in addition to the initial 120 days allowed to request a SFH.	1. All letters reviewed for NAR language/attachment 2. Updated Desk Level Process 3. Report created for look back period of 120 days to re-review 4. Audit conducted of letters 5. Staff re-education	1. 1.1.3.1.1_SFHRsponse 2. 1.3.1.2_AppealsRview 3. 1.3.1.3_UpheldNARs 4. 1.3.1.4.1_NARAuditQ1 1.3.1.4.2_NARAuditQ1 5. 1.3.1.5.1_EMail42023 1.3.1.5.2_EMail1222	1. 4/12/2023 2.10/13/2020 3. 5/15/2023 4. 4/16/2023 5. 12/9/2022 4/10/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Appeals Review Process DLP directs staff to include State Fair Hearing Extension letter with upheld NARs during the public health emergency. **MONITORING AND OVERSIGHT** » Upheld NAR Look Back report and Q1 NAR Audit report demonstrate the MCP created a process to monitor the inclusion of the SFH timeframe extension attachment. **TRAINING** » Email communication dated 12/9/23 demonstrates MCP educated staff of the requirement to include SFH extension letters with upheld NARs during the public health emergency. » Email communication dated 5/12/23 demonstrates staff has been informed SFH extension letter no longer required as the public health emergency has ended. **The corrective action plan for finding 1.3.1 is accepted.**

2. Case Management and Coordination of Care

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
2.1.1 Provision of an IHA The Plan did not ensure the provision of a complete IHA to each new member.	1. Policy revised 2. IHA bulletin drafted 3. IHA audit tool updated 4. Educational Letter to non-compliant providers 5. Educational Letter to non-compliant providers 6. Educational Letter template	1. 2.1.1.1_2.73-P IHA 2. 2.1.1.2_IHA Bulletin 3. 2.1.1.3_2.73-P AttA 4. 2.1.1.4.1_IHAEducLtr 5. 2.1.1.4.2_IHAEducLtr 6. 2.1.1.5_2.73-P AttB	1. Upon DHCS Approval 2. 6/2/2023 3. 6/1/2023 4. 6/1/2023 5. 6/1/2023 6. 6/1/2023	The following documentation supports the MCP's efforts to correct this finding: POLICIES AND PROCEDURES » "2.73-P Initial Health Appointment" demonstrates it is the Plan's responsibility to educate providers about performing the IHA through provider trainings, Provider Bulletins, all information & training module available on the Plan's website, and/or individual education by Provider Network Management Representatives, Quality Improvement Nurses, or the Health Education team. (2.73-P IHA, Procedures,1. C., page 3) **MONITORING AND OVERSIGHT** » "2.73-P Initial Health Appointment" demonstrates the Plan's 3 mechanisms for tracking & monitoring timely completion of IHAs: Provider Site Reviews – The completeness of IHA & the medical record review is monitored. If non-compliance is identified, the site review nurse educates the provider on requirements & issues a corrective action plan. Monthly IHA Members Report – lists all members who are compliant & non-compliant for receiving IHA & sends educational information letter to both the member & PCP.

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				Semi-annual audit of IHA Members Report – a designated QI nurse completes a random selection audit of providers. by sampling a minimum of 100 newly enrolled members identified from the IHA members report listed as compliant. The audit tool's purpose is to demonstrate all components of the IHA have been completed & documented. Non-compliant providers receive an informational & educational letter advising them of the deficiencies & what the expectations are for the assessment. (2.73-P IHA, IHA Monitoring, A. page 3) » "IHA Audit Tool" demonstrates the Plan's monthly monitoring process that captures all requirements being fulfilled for any new members which is used to confirm that an IHA has been completed within first 120-days. (2.1.1.3_2.73-P Att. A) » "IHA Bulletin" demonstrates the Plan notified all providers of the changes made to the IHA requirements with APL 22-030: Change from Initial Health Assessment to Initial Health Appointment. Individual Health Education Behavioral Assessment (IHEBA) & Staying Healthy Assessment (SHA) are no longer required as part of the IHA. An IHA must be completed within 120 days & include the following, a history of the Member's physical & mental health; an identification of risks; an assessment of need for preventive

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				screens or services; health education; & the diagnosis and plan for treatment of any diseases. (2.1.1.2_IHA Bulletin) **TRAINING** » Two sample letters, "IHA Educ Ltr" demonstrate the Plan sends out notification of the IHA audit performed & shares the results along with provider education should there be any issues. (2.1.1.4.1_IHAEducLtr and 2.1.1.4.2_IHAEduLtr) **The corrective action plan for finding 2.1.1 is accepted.**
2.1.2 IHA Scheduling Attempts The Plan did not make and document reasonable attempts to contact members and schedule IHAs.	N/A	N/A	N/A	N/A
2.5.1 Alcohol and Substance Use Disorder Treatment Services The Plan did not make good faith	1. KHS Policy updated 2. Monthly Reconciliation report created and shared between KBHRS and KHS for all referred members 3. Developing new process for staff to follow up with member when	1. 2.5.1.1_Alc&SUDTxSvc 2. 2.5.1.2_MnthlyRefRpt 3. In Process	1. 5/1/2023 2. 6/5/2023 3. 7/1/2023 4. 05/22/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Policy Alcohol and Substance Use Disorder Treatment Services 5/9/23 updated to include MCP will send the monthly SUD referral outcome report to KBHRS for reconciliation on all

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
efforts to confirm whether members received referred treatments for alcohol and substance use disorder.	unable to obtain referral outcome from county to confirm when they were linked and where they were linked. 4. BH Director presented to all providers during the monthly County provider meeting on 5/22/23 to address process for coordination of care with MCP and the need for ROIs to exchange data. 5. Meetings with county to discuss coordination of care			referrals submitted requesting data to confirm member was linked for treatment. For members KBHRS is unable to obtain Release of Information, KHS will contact member to confirm whether treatment was received and track when and where. » SUD Referral Process DLP contains process for staff to conduct outreach to member to complete warm handoff to SUD gateway staff. **MONITORING AND OVERSIGHT** » Monthly Reconciliation Report to track members referred to KBHRS for SUD treatments demonstrates the MCP has a method for monitoring receipt of treatment. » SUD Treatment Providers Meeting from 5/23/23 the MCP addressed process for coordination of care with MCP and the need for ROIs to exchange data. » Meeting minutes from 1/9/23, 2/6/23, 3/6/23/ 5/15/23 demonstrate the MCP has discussed coordination of care with the county. **The corrective action plan for finding 2.5.1 is accepted.**
2.5.2 Primary Care Provider Scope of Practice	1. KHS Policy created "Scope of Services"	1. 2.5.2.1_ScopeofSvcs	1. Upon DHCS approval of policy (tentative 7/1/2023)	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
The Plan policy did not define and describe what outpatient mental health services are to be provided by the PCPs.				» MCP created Scope of Services Policy which describes outpatient mental health services. 2.5.2.1_ScopeofSvcs (Page 4-5). **The corrective action plan for finding 2.5.2 is accepted.**

3. Access and Availability of Care

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
3.1.1 Timely Access and Network Adequacy Corrective Actions The Plan did not conduct prompt investigation and corrective action for providers found to be non-compliant with access standards in the annual Provider Appointment Availability Survey (PAAS).	1. Policy updated to include wording for monitoring 2. Letters sent to non-compliant providers identified via RY 2023 DMHC PAAS survey	1. 3.1.1.1_KHS_4.30-P 2. 3.1.1.2.1_PAAS_Let 3.1.1.2.2_Policy	1. 6/1/2023 2. 6/1/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » "KHS_4.30-P" Accessibility Standards (page 19, 26) » The Plan submitted a revised P&P that automatically sends notice letters to individual PAAS-noncompliant providers and educating them on the Plan's accessibility standards » On top of the Plan's quarterly monitoring, providers are further subject to requests for additional evidence and information **MONITORING AND OVERSIGHT** » "KHS_4.30-P" Accessibility Standards (page 26) The Plan added revised language stating providers will be subject to quarterly monitoring, but requests for additional evidence and information including timely access surveys, complaints/grievances/appeals investigations, issues of contractual and policy noncompliance, etc. » PAAS_Let The Plan submitted a series of notification letters that were already sent to noncompliant of providers, communicating their

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				noncompliance with access & availability standards, a copy of which was included with the letters Additionally, incidents of noncompliance are reviewed for substantial harm on members and trended for potential patterns of noncompliance (page 19, 20) "Policy" KHS Policy, 4.30-P Accessibility Standards With each CAP letter, the Plan also sends noncompliant providers the current policy on accessibility standards **The corrective action plan for finding 3.1.1 is accepted.**
3.1.2 Monitoring Provider Office Wait Times The Plan did not monitor appointment wait times in providers' offices.	1. Policy updated to capture new monitoring process 2. Survey Tool Updated 3. Survey Tool implemented for surveys to be conducted during Q2 2023	1. 3.1.2.1_KHS_4.30-P 2. 3.1.2.2_KHS_Survey	1. 6/1/2023 2. 6/1/2023 3. 6/1/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » "Policy" KHS Policy, 4.30-P Accessibility Standards (page 15) The Plan revised their P&P to include an access & availability survey sent to providers on a quarterly basis gauging compliance with office wait times. **MONITORING AND OVERSIGHT** » KHS Survey

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				» The Plan submitted a survey gauging compliance with access & availability standards, question #4 - specifically asking about providers' current in-office wait times. The Plan seeks to implement and conduct the survey during Q2 of 2023. » KHS Provider Accessibility Monitoring Survey Results (Quarter 2, 2023) The Plan has conducted a quarterly survey in order to monitor appointment wait times in providers' offices. All individual office results were compliant with the in-office wait time standard. **The corrective action plan for finding 3.1.2 is accepted.**
3.1.3 Monitoring Telephone Access The Plan did not monitor the time it took for providers to answer and return telephone calls from members.	1. Policy updated to capture new monitoring process 2. Survey Tool Updated 3. Survey Tool implemented for surveys to be conducted during Q2 2023	1. 3.1.3.1_KHS_4.30-P 2. 3.1.3.2_KHS_Survey	1. 6/1/2023 2. 6/1/2023 3. 6/1/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » "Policy" KHS Policy, 4.30-P Accessibility Standards (page 15) The Plan revised their P&P to include an access & availability survey which will be sent to providers on a quarterly basis gauging compliance timeframe to answer and return calls. **MONITORING AND OVERSIGHT**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				» KHS Survey The Plan submitted a survey gauging compliance with access & availability standards, question #5 and 6 - specifically asking about timeliness. regarding answering/returning telephone calls The Plan seeks to implement and conduct the survey during Q2 of 2023. » KHS Provider Accessibility Monitoring Survey Results (Quarter 2, 2023) The Plan has conducted a quarterly survey in order to monitor the time it took for providers to answer and return telephone calls from members. Providers were compliant with the rings to answer standard. **The corrective action plan for finding 3.1.3 is accepted.**
3.6.1 Family Planning Claims Denial The Plan improperly denied family planning claims.	1. Claims identified reprocessed and presented during audit including any applicable interest. 2. Staff Re-education 3. Update DX codes to Family Planning exception report to allow w/o authorization.	1. 3.6.1.1.1_CL_CORR_1 3.6.1.1.2_CL_CORR_2 3.6.1.1.3_CL_CORR_3 2. 3.6.1.2.1_ATTEND_LOG 3.6.1.2.2_FPDOCUMENT 3. 3.6.1.3_FP_DX_RPT	1. 10/25/2022 10/25/2022 9/13/2022 2. 5/31/2023 6/1/2023 3. 6/2/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » P&P, "3.21-P: Family Planning Services" to demonstrate that non-contract providers are paid for services provided to Medi-Cal members based on the appropriate Medi-Cal FFS rates. **TRAINING**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
		3.6.1.3a_FP_DX_RPT		» "Family Planning" claims training and attendance log (05/31/23) which demonstrates that the MCP conducted staff re-training on requirements for Family Planning Claims. Family planning services are payable to contracted and non-contracted providers without an authorization. (3.6.1.2.2_FPDOCUMENT). **MONITORING AND OVERSIGHT** » "Family Planning and Sensitive Services Audit Report" (07/13/23) to demonstrate that the MCP has a monitoring process to review family planning claims that were denied. The MCP's Senior Examiner/Auditor will review the report and pend any claims that are denying inappropriately to be reworked before final adjudication. The report is processed each day and those that should not deny are corrected. (FP_DX_RPT, FP_RPT2). **The corrective action plan for finding 3.6.1 is accepted.**
3.8.1 Prior Authorization for NEMT The Plan did not require prior authorization for NEMT ambulance,	1. Corrective Actions will be defined following receipt of DHCS clarification	1. 3.8.1.1_DHCS Email		The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Updates to policy "5.15-I_Member Transportation Assistance" demonstrates the revisions the Plan made to align with APL 22-008 that prior authorization is required for NEMT ambulance,

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
wheelchair, and litter van services.				wheelchair & litter van services. (5.15-I, Procedures, 1.1.1-1.1.2, 1.2 & 1.4, pages 4-5) » Updates to policy "5.15-P_ Member Transportation Assistance" demonstrates the revisions the Plan made to align with APL 22-008 stating NEMT for litter van, wheelchair van & ambulance services require prior authorization. (5.15-P, Procedures, 1.1-1.3 & 1.5, pages 4-5) **MONITORING AND OVERSIGHT** » Updates to policy "5.15-I_Member Transportation Assistance & 5.15-P_Member Transportation Assistance" demonstrates the revisions made to the Plan's PA process where the Plan's transportation broker reviews the member's file to verify eligibility for NEMT services being requested verifying that the PCS form is valid & that the member's trip destination is a Medi-Cal covered service. (5.15-I, Procedures, 1.4, page 5) (5.15-P, Procedures, 1.5, page 5) Policy also states that the Plan will impose corrective action on transportation providers and brokers who are found to be non-compliant with these requirements. (5.15-I, 11.3, page 14) (5.15-P, 10.3, pages 10-11) "3.8.1.2.6_Trans_Broker_Scrpt" demonstrates the transportation broker's process when verifying eligibility for members when NEMT services are requested. The member services verifies a

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				valid completed PCS form is on file with the dates of services, & that it is a Medi-Cal covered service. If the requirements are not met, NEMT is not provided to the requested location. *The Plan's revisions to its policies & procedures regarding the need for prior authorization for NEMT ambulance, wheelchair & litter van services meet the requirements to correct this finding.* **The corrective action plan for finding 3.8.1 is accepted.**

4. Member's Rights

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
4.1.1 Grievance Resolution Timeframe The Plan did not resolve standard grievances within the required 30 calendar day timeframe.	1. Currently, the Plan allows for Providers to take 10 business days with a 5-business day follow up. The Plan will be changing the timeframes to 7 calendar days for the initial request with a 3-calendar day follow up. This will allow the Plan more time to outreach to the providers should they not respond timely to requests for information to resolve the members' grievances. Provider Bulletin with update sent to Plan providers on 6/2/2023. 2. Reports were created during the reporting period that identified grievances noted in the core information system that were closed without being assigned to the Grievance team. The Plan is in process of modifying this report further to improve the capturing and reporting of member grievances.	1. 4.1.1.1_PrBulletin 2. 4.1.1.2_GAClosedRpt 3. 4.1.1.3_Redline5.01 4.1.1.3_Desktop Proc 4. 4.1.1.4.1_GAAgingReq 4.1.1.4.2_GAAgingReq 5. In Process	1. 6/1/2023 2. 6/19/2023 3. 6/7/2023 4. 6/19/2023 5. 6/19/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Drafted Revised P&P's, 5.01-I, "KHS Member Grievance and Appeal System" (06/2023). The Plan has revised this P&P to reference their updated procedure in regard to changing the timeframes to seven-calendar days instead of ten-calendar days for the initial request and a three-calendar day follow up instead of five-calendar days follow up for Providers to respond timely to requests for information. In addition, the Plan removed from this P&P the language, "which shall not exceed 14 calendar days." (4.1.1.3 Redline 5.01) » Desktop Procedure, "Pended Grievance or Appeal" (04/17/23) demonstrates the Plan has created a desktop procedure to inform G&A staff that effective immediately, that they can longer pend grievances and the importance of making sure they are requesting medical records and responses from the provider in a timely manner. (4.1.1.3 Desktop Proc) » Desk Level Process, "Grievance and Appeal Audit Process" (07/23) demonstrates the Plan has an audit process to verify if QOS grievance resolution letters are being sent within the 30-calendar day timeframe. Plan's goal: Audit a total of 30 case files with a 90%

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	3. The Plan removed all language from Policy 5.01-I/P and desk level procedures that indicate a grievance or appeal can be pended for further investigation. 4. The Plan is in process of creating an aging system in the Grievance Log that once a Grievance received date is entered in the log, it will create reminders to ensure no grievances are closed outside of the 30-day period. 5. Work with other Plan Departments to develop a Corrective Action Plan (CAP) threshold for providers who do not respond to Grievance requests timely.			or above passing score each quarter. Grievance Coordinator (GC) Leads will randomly audit a total of 10 audits on a monthly basis to support the quarterly goal. (4.1.1.2 Audit DLP.pdf) If less than 90% on monthly audit, the GC Lead will address areas of deficiency and corrections. If repeat deficiencies are noted in one or more areas during three consecutive audits, in addition to correcting the area of deficiency, the Grievance Coordinator (GC) will be required to meet 1:1 with a Supervisor, GC Lead, or their designee and/or additional training will be required. » Revised Process, "Provider Bulletin, Grievance and Appeals Update" (06/02/23) currently, the Plan allows for Providers to take 10 business days with a five-business day follow up. The Plan will be changing the timeframes to 7 calendar days for the initial request with a three-calendar day follow up. This will allow the Plan more time to outreach to the providers should they not respond timely to requests for information to resolve the members' grievances. Provider Bulletin with update sent to Plan providers on 6/2/2023. (4.1.1.1 PrBulletin) » Process, "Provider CAP Letter and CAP Process" (07/23) demonstrates the Plan has developed a provider CAP letter and process to implement when a provider is out of compliance to requests for responses and/or medical records for plan grievance investigations. (4.1.1 ProvCAPLetter and 4.1.1 ProvCAPProcess)

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				MONITORING AND OVERSIGHT » Modification, "DHCS Grievance Log and Appeal Log" (06/02/23). The Plan is in the process of creating an aging system in the Grievance Log that once a Grievance received date is entered in the log, it will create reminders to ensure no grievances are closed outside of the 30-day period. (4.1.1.4.1 GAAgingReq and 4.1.1.4.2 GAAgingReq) » Report, "GA Closed Report" (05/23) these were created during the reporting period that identified grievances noted in the core information system that were closed without being assigned to the Grievance team. The Plan is in process of modifying this report further to improve the capturing and reporting of member grievances. (4.1.1.2_GAClosedRpt) » Report, Modified, "GA Closed Report" (07/23) the Plan added additional call codes from our core information system to the GA Closed Report. By adding more call codes that MSRs use every day, it allows the Plan to search and identify more member dissatisfactions that may not have been assigned to the Grievance Coordinators on a daily basis. (4.1.1.2.2 GAClsdRpt.pdf) » Audit Tool, "Grievance Audit" (07/23) demonstrates the Plan is monitoring QOS grievance resolution letters for the 30-calendar day timeframe response. (4.1.1.2 Audit DLP)

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				» Audit Results, "Grievance Audit" (Audit dates 08/07/23-08/11/23) which demonstrates that standard grievance resolution letters are being sent to members within the required 30-day calendar time frame. (4.1.1.2.1 Audit Rslts.pdf) **TRAINING** » Meetings, "Team Meetings" (05/31/23, 06/01/23, 06/05/23, and 06/06/23) demonstrates the Plan met with the Grievance Team in regard to the following agenda items: Screening Tool Standard Grievance Process QOC Grievance Job Aid Medical Records – Provider Responses, Request Guide Pending Grievances Exempt Grievances » Attestations are included. (4.1.1_ResTimeframe) **The corrective action plan for finding 4.1.1 is accepted.**
4.1.2 Grievance Resolution The Plan did not fully investigate and	1. Currently, the Plan allows for Providers to take 10 business days with a 5-business day follow up. The Plan will be changing the timeframes	1. 4.1.2.1_PrBulletin 2. 4.1.2.2_Redline5.01 3. In Process	1. 6/2/2023 2. 6/7/2023 3. 6/19/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
resolve grievances prior to sending resolution letters.	to 7 calendar days for the initial request with a 3-calendar day follow up. This will allow the Plan more time to outreach to the providers should they not respond timely to requests for information to resolve the members' grievances. Provider Bulletin with update sent to Plan providers on 6/2/2023. 2. If the Plan is not able to resolve the grievance by reviewing internal records, then on or before the 20th day in the Grievance process, the Plan will follow up with the Provider by phone call to check on the status of the written response and/or records if necessary. If written response cannot feasibly be received by the Provider to close the grievance timely, then at that time, a verbal response will be requested from the Provider, capturing date, time, name of person providing response and pertinent details of			» Drafted Revised P&P's, 5.01-I, "KHS Member Grievance and Appeal System" (06/2023). The Plan has revised this P&P to reference their updated procedure in regard to changing the timeframes to seven-calendar days instead of ten-calendar days for the initial request and a three-calendar day follow up instead of a five-calendar days follow up for Providers to respond timely to requests for information. (4.1.2.2 Redline5.01) » Desk Level Process, "Grievance and Appeal Audit Process" (08/23) demonstrates the Plan has an audit process to verify if grievances are fully investigated and resolved prior to sending resolution letters. The Plan's goal is to audit a total of 30 case files with a 90% or above passing score each quarter. Grievance Coordinator (GC) Leads will randomly audit a total of 10 audits on a monthly basis to support the quarterly goal. If less than 90% on monthly audit, the GC Lead will address areas of deficiency and corrections. If repeat deficiencies are noted in one or more areas during three consecutive audits, in addition to correcting the area of deficiency, the Grievance Coordinator (GC) will be required to meet 1:1 with a Supervisor, GC Lead, or their designee and/or additional training will be required. (4.1.2.3.2 DLP) » Revised Process, "Provider Bulletin, Grievance and Appeals" (06/02/23) currently, the Plan allows for Providers to take 10 business days with a five-business day follow up. The Plan will be

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	response to present to Grievance Review Committee for closure. 3. Work with other Plan Departments to develop a Corrective Action Plan (CAP) threshold for providers who do not respond to Grievance requests timely.			changing the timeframes to 7 calendar days for the initial request with a three-calendar day follow up. This will allow the Plan more time to outreach to the providers should they not respond timely to requests for information to resolve the members' grievances. Provider Bulletin with update sent to Plan providers on 6/2/2023. (4.1.2.1 PrBulletin) **MONITORING AND OVERSIGHT** » Audit Tool, "Grievance Audit" (07/23) demonstrates the Plan is monitoring QOC/QOS grievance resolution letters to make certain that grievance resolution letters are fully investigated and with resolution that is clear and concise. (4.1.2.3.1 Audit Tool) » Audit Results, "Grievance Audit" (Audit dates 08/07/23-08/11/23) which demonstrates that grievances are being fully investigated and resolved prior to sending resolution letters. (4.1.2.3.2 AuditRslts) » Process, "Provider CAP Letter and CAP Process" (07/23) demonstrates the Plan has developed a provider CAP letter and process to implement when a provider is out of compliance to requests for responses and/or medical records for plan grievance investigations. (4.1.2 ProvCAPLetter and 4.1.2 ProvCAPProcess) **TRAINING**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				» Meetings, "Team Meetings" (05/31/23, 06/01/23, 06/05/23, and 06/06/23) demonstrates the Plan met with the Grievance Team in regard to the following agenda items: Screening Tool Standard Grievance Process QOC Grievance Job Aid Medical Records – Provider Responses, Request Guide Pending Grievances Exempt Grievances » In regard to pending grievances at the 5/31/23 Team Meeting, the Plan discussed with the team that pending grievances are no longer allowed and if the response is not received from the providers, to reach out to leads and management for authorization to delay the case. If resolution of a grievance is not reached within 30 calendar days as required, the Plan will notify the member in writing of the status of the grievance (notification of delay letter) reason for delay and estimated date of resolution. (4.1.2 GrievResolutn) **This corrective action plan for finding 4.1.2 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
4.1.3 Notice of Grievance Resolution Delay The Plan did not send written notification informing members of grievance status and an estimated resolution date when standard grievances exceeded the 30-calendar day resolution timeframe.	1. The Plan is creating an aging system in the Grievance Log that once a Grievance received date is entered in the log, it will create reminders to ensure a grievance resolution letter is mailed timely within 72 hours to 30 calendar days. 2. The Plan removed all language from Policy 5.01-I/P and desk level procedures that indicate a grievance or appeal can be pended for further investigation. 3. Provide updated training to Grievance and Member Services Staff. 4. Monthly Grievance Oversight Case File Audits. Results will be reported to the quarterly Compliance Committee Meeting starting in July 2023.	1. 4.1.3.1_GAAgingReq 4.1.3.1.2_GAAgingReq 2. 4.1.3.2_Redline5.01 3. 4.1.3.3.1_Agnda12523 4.1.3.3.2_Agnda22223 4.1.3.3.3_Agnda32923 4.1.3.3.4_Agnda42623 4.1.3.3.5_Agnda52423 4.1.3.3.6_GAOvrvw123 4.1.3.3.7_GAOvrvw323 4.1.3.3.8_GAOvrvw423 4.1.3.3.9_GAOvrvw523 4.1.3.3.10_GCProcess 4. 4.1.3.4_GAAuditTool	1. 6/19/2023 2. 6/7/2023 3. January 2023 to current 4. 6/1/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Drafted Revised P&P's, 5.01-I, "KHS Member Grievance and Appeal System" (06/2023). The Plan has revised this P&P to state, if the Plan is not able to resolve the grievance by reviewing internal records, then on or before the 20th day in the Grievance process, the Plan will follow up with the Provider by phone call to check on the status of the written response and/or records if necessary. If written response cannot feasibly be received by the Provider to close the grievance timely, then at that time, a verbal response will be requested from the Provider, capturing date, time, name of person providing response and pertinent details of response to present to Grievance Review Committee for closure. » In addition, the Plan has removed the 14-day extension to grievances language. (4.1.3.2 Redline5.01) **MONITORING AND OVERSIGHT** » Modification, "DHCS Grievance Log and Appeal Log" (06/02/23). The Plan is in the process of creating an aging system in the Grievance Log that once a Grievance received date is entered in the log, it will create reminders to ensure a grievance resolution

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				letter is mailed timely within 72 hours to 30 calendar days. (4.1.3.1.1 GAAgingReq and 4.1.3.1.2 GAAAgingReq) » Audit Tool, "Grievance Audit Tool" (07/23) demonstrates the Plan is monitoring resolution letters that have exceeded the 30-calendar day timeframe and verifying if delay letter is being mailed to member. » The Plan has implemented the audit tool in July 2023 for grievances received in June 2023. Findings to be reported to Plan's Compliance Committee starting October 2023 with June, July, and August data. (4.1.3.4 AuditTool) » Audit Results, "Grievance Audit" (Audit dates 08/07/23-08/11/23) which demonstrates the Plan is sending written notification informing members of grievance status and an estimated resolution date when standard grievances exceed the 30-calendar day resolution timeframe. (4.1.3.4 AuditRslts) » Report, "Aging Delay Report" (06/23) demonstrates the Plan has an internal audit process to verify if delay letters are being sent if the 30-day timeframe for a resolution letter is not met. This report will be sent daily to Grievance staff to show what case files are near the 30-day resolution timeframe so that a delay letter can be mailed to member if not able to resolve the grievance timely.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				Management oversees the daily report and distribution of report to staff. (4.1.3 AgingDelayRpt) **TRAINING** » Meeting, "Grievance and Appeal Team Meetings" (05/31/23, 06/01/23, 06/05/23, and 06/06/23) demonstrates the Plan implemented a process change for pending grievances. The plan will no longer pend grievances. If a grievance is not resolved within the 30-calendar day resolution timeframe, the plan will mail the member a written notification informing them their grievance resolution is delayed and provide an estimated resolution date. (4.1.3 Grievance Delay) **This corrective action plan for finding 4.1.3 is accepted.**
4.1.4 Grievance Acknowledgement Letters The Plan did not send grievance acknowledgment letters to members within the required five calendar day timeframe.	1. The Plan is creating an aging system in the Grievance Log that once a Grievance received date is entered in the log, it will create reminders to ensure a grievance acknowledgement letter is mailed timely within 72 hours to 5 calendar days.	1. 4.1.4.1.1_GAAgingReq 4.1.4.1.2_GAAgingReq	1. 6/19/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Desk Level Process, "Grievance and Appeal Audit Process" (07/23) demonstrates the Plan has an audit process to verify if QOS/QOC grievance acknowledgement letters are being sent timely to members within the required five calendar day timeframe. The Plan's goal is to audit a total of 30 case files with a 90% or above passing score each quarter. Grievance Coordinator (GC) Leads will

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				randomly audit a total of 10 audits on a monthly basis to support the quarterly goal. » If less than 90% on monthly audit, the GC Lead will address areas of deficiency and corrections. If repeat deficiencies are noted in one or more areas during three consecutive audits, in addition to correcting the area of deficiency, the Grievance Coordinator (GC) will be required to meet 1:1 with a Supervisor, GC Lead, or their designee and/or additional training will be required. (4.1.4.1 Audit DLP) **MONITORING AND OVERSIGHT** » Modification, "DHCS Grievance Log and Appeal Log" (06/02/23). The Plan is in the process of creating an aging system in the Grievance Log that once a Grievance received date is entered in the log, it will create reminders to ensure no grievances are closed outside of the 30-day period. (4.1.4.1.1 GAAgingReq and 4.1.4.1.2 GAAgingReq) » Audit Tool, "Grievance Audit Tool" (07/23) demonstrates the Plan is monitoring grievance acknowledgement letters are being sent to members within the required five calendar time frame. (4.1.4.1 Audit DLP.pdf) » Audit Results, "Grievance Audit" (Audit dates 08/07/23-08/11/23) which demonstrates the Plan is sending acknowledgement letters

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				to members within the required five calendar day timeframe. (4.1.4.1 Audit Rslts) **TRAINING** » Meeting, "Grievance and Appeal Team Meetings" (01/25/23, 03/29/23, 04/26/23, 05/24/23, 05/31/23, 06/01/23, 06/05/23, and 06/06/23) demonstrates the Plan conducted Grievance and Appeal monthly staff meetings regarding Acknowledgement letters now being sent within three calendar days from the member filing the grievance to verify it is sent within the required five calendar day timeframe. (4.1.4.1 Acknowl Ltrs) **The corrective action plan for finding 4.1.4 is accepted.**
4.1.5 Grievance Resolution Letters The Plan did not ensure grievance resolution letters were clear and concise.	1. Content of resolution letter has been updated to include all actions taken to ensure member grievance outcome are clear, concise, and fully resolve the member's complaint. 2. Plan Medical Director has been assigned to review and identify appropriate follow up actions required for Quality-of-Care Grievances. The Plan Medical Director also provides a clear and	1. 4.1.5.1_GAQOCRes 2. 4.1.5.2_MDQOCRes	1. 6/7/2023 2. 6/7/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Revised P&P, 5.01-I, "KHS Member Grievance and Appeal System" (07/2023). The Plan has revised this P&P to state, "A resolution to the member's grievance is written from the Medical Director's recommendation and will include a clear and concise explanation of the Medical Director's decision. (4.1.5 Redline5.01) » Desk Level Process, "Grievance and Appeal Audit Process" (07/23) demonstrates the Plan has an audit process to verify if QOS/QOC grievance resolution letters are clear and concise. The Plan's goal

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	concise resolution statement for all Quality-of-Care grievances.			is to audit a total of 30 case files with a 90% or above passing score each quarter. Grievance Coordinator (GC) Leads will randomly audit a total of 10 audits on a monthly basis to support the quarterly goal. The Plan's goal is to audit a total of 30 case files with a 90% or above passing score each quarter. Grievance Coordinator (GC) Leads will randomly audit a total of 10 audits on a monthly basis to support the quarterly goal. If less than 90% on monthly audit, the GC Lead will address areas of deficiency and corrections. If repeat deficiencies are noted in one or more areas during three consecutive audits, in addition to correcting the area of deficiency, the Grievance Coordinator (GC) will be required to meet 1:1 with a Supervisor, GC Lead, or their designee and/or additional training will be required. (4.1.5 Audit DLP) **MONITORING AND OVERSIGHT** » Job Aid, "QOC Grievance Job Aid" (05/23) demonstrates the Plan guides the Grievance Coordinators, Case Management Team, Medical Director, and Grievance Review Committee to make certain that all QOS/QOC grievance resolution letters are clear and concise. (4.1.5 GCProcess.pdf)

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				» Revised, Job Aid, "QOC Grievance Job Aid" (09/23) revised to state, "Medical Director to make a determination if the grievance will be closed or delayed. A clear and concise resolution is required prior to closing." (4.1.5 GCProcess.pdf) » Revised Resolution Letter, "GA Resolution Letter" and "MD Grievance Resolution Form" (06/07/23) demonstrates the Plan has revised resolution letters to include all actions taken to confirm member grievance outcomes are clear, concise, and fully resolve the member's complaint. (4.1.5.1 GAQOCRes.pdf) In addition, Plan Medical Director has been assigned to review and identify appropriate follow up actions required for Quality-of-Care Grievances. The Plan Medical Director also provides a clear and concise resolution statement for all Quality-of-Care grievances.(4.5.1.2 MDQOCRes) » Audit Tool, "Grievance Audit Tool" (07/23) demonstrates the Plan is monitoring grievance resolution letters for clear and concise language. (4.1.5.1 Audit Tool) » Audit Results, "Grievance Audit" (Audit dates 08/07/23-08/11/23) which demonstrates the Plan is sending grievance resolution letters with clear and concise language. (4.1.4.1 Audit Rslts) **TRAINING**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				» Meeting, "Grievance and Appeal Team Meetings" (01/25/23, 03/29/23, 04/26/23, 05/24/23, 05/31/23, 06/01/23, 06/05/23, and 06/06/23) demonstrates the Plan conducted Grievance and Appeal monthly staff meetings in regard to the resolution letter process. (4.1.5 GCProcess.pdf) **The corrective action plan for finding 4.1.5 is accepted.**
4.1.6 Written Member Consent for Grievances The Plan did not obtain written consent from the member when someone other than the member filed a grievance on behalf of the member.	1. The Plan will draft an Appointment of Representative (AOR) Form to mail to members, with postage paid return envelope, when someone wants to file a grievance or appeal on the member's behalf.	1. 4.1.6.1_Draft AOR	1. 6/19/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Revised P&P, 5.01-I, "KHS Member Grievance and Appeal System" (07/2023). The Plan has revised this P&P to state, "Written consent from the member must be received by the Plan when someone other than the member files a complaint on members behalf." (4.1.6 Redline5.01) **MONITORING AND OVERSIGHT** » Desk Level Process, "Grievance and Appeal Audit Process" (07/23) demonstrates the Plan has an audit process to validate if QOS/QOC grievances are being filed by the member or someone other than the member. The Plan's goal is to audit a total of 30 case files with a 90% or above passing score each quarter. Grievance Coordinator (GC)

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				Leads will randomly audit a total of 10 audits on a monthly basis to support the quarterly goal. If less than 90% on monthly audit, the GC Lead will address areas of deficiency and corrections. If repeat deficiencies are noted in one or more areas during three consecutive audits, in addition to correcting the area of deficiency, the Grievance Coordinator (GC) will be required to meet 1:1 with a Supervisor, GC Lead, or their designee and/or additional training will be required. (4.1.6 Audit DLP) » Drafted Form, "Appointment of Representative Form" (06/19/23) demonstrates the Plan has created a form to mail to members, with postage and paid return envelope, when someone wants to file a grievance or appeal on the member's behalf. (4.1.6.1 Draft AOR) » Audit Tool, "Grievance Audit Tool" (07/23) demonstrates the Plan is monitoring grievances when someone other than the member filed a grievance on behalf of the member. (4.1.6 Audit Tool) » Audit Results, (10/13/23 – 11/01/23) eight grievances were reviewed for this CAP, all eight cases were filed by members authorized representative. Written consent was obtained. (4.1.6_AOR Audit) **TRAINING**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				» Team Meeting, "Appointment of Representative" (08/15/23) demonstrates the Plan discussed with their Grievance Coordinators the process of obtaining member consent before allowing others to file a grievance on behalf of the member. (4.1.6_Member Consent-2) (4.1.6_Member Consent -3) **The corrective action plan for finding 4.1.6 is accepted.**
4.1.7 Designated Discrimination Grievance Coordinator The Plan did not have a designated discrimination grievance coordinator.	1. The Plan updated the Grievance Organizational Chart to identify designated Discrimination Grievance Coordinators	1. 4.1.7.1_GAOrgChart	1. 6/7/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » MCP updated its Grievance Organizational chart to identify designated Discrimination Grievance Coordinators. **The corrective action plan for finding 4.1.7 is accepted.**
4.1.8 Classification of Discrimination Grievances The Plan did not adopt procedures that provide for	1. KHS will implement a screening tool to be used to help classify all grievances accurately. 2. Monthly Grievance Oversight Case File Audits. Results will be reported to the quarterly Compliance	1. 4.1.8.1_GAScreenTool 2. 4.1.8.2_GAAuditTool	1. 6/1/2023 2. 6/1/2023	The following documentation supports the MCP's efforts to correct this finding: **MONITORING AND OVERSIGHT**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
prompt and equitable resolution of discrimination grievances.	Committee Meeting starting in July 2023.			» G&A Screening Tool is used by the MCP to accurately classify grievances. The tool contains a series of questions related to discrimination. Tool has been in use since 6/1/23 » G&A Audit Tool will be used for monthly audits of grievance files to be reported to the quarterly Compliance Committee Meetings. MCP will audit 10 cases per month and 30 cases per quarter. **The corrective action plan for finding 4.1.8 is accepted.**
4.1.9 Notification of Discrimination Grievances The Plan did not notify DHCS within ten calendar days of mailing a discrimination grievance resolution letter to a member.	1. The Plan is creating an aging system in the Grievance Log that once a Grievance received date is entered in the log, it will create reminders to ensure the Discrimination Grievance case is sent to DHCS OCR within 10 days of the resolution date. 2. Monthly Grievance Oversight Case File Audits. Results will be reported to the quarterly Compliance Committee Meeting starting in July 2023.	1. 4.1.9.1.1_GAAgingReq 4.1.9.1.2_GAAgingReq 2. 4.1.9.2_GAAuditTool	1. 6/19/2023 2. 6/1/2023	The following documentation supports the MCP's efforts to correct this finding: **MONITORING AND OVERSIGHT** » Discrimination Grievance Aging Log is used to create reminders for staff to inform them that discrimination grievances need to be sent to DHCS within 10 days of the sending of the resolution letter. » G&A Audit Tool will be used for monthly audits of grievance files to be reported to the quarterly Compliance Committee Meetings. The tool has a field to confirm that the discrimination grievances was sent to DHCS within 10 calendar days. MCP will audit 10 cases per month and 30 cases per quarter. **The corrective action plan for finding 4.1.9 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
4.1.10 (Repeat of 2021 4.1.3) Classification of Grievances The Plan did not properly classify members' expressions of dissatisfaction as grievances.	1. Reports were created during the reporting period that identified grievances noted in the core information system that were closed without being assigned to the Grievance team. The Plan is in process of modifying this report further to improve the capturing and reporting of member grievances. 2. Provide updated training to Grievance and Member Services Staff.	1. 4.1.10.1_GAClosedRpt 2. 4.1.10.2.1_Agnd12523 4.1.10.2.2_Agnd22223 4.1.10.2.3_Agnd32923 4.1.10.2.4_Agnd42623 4.1.10.2.5_Agnd52423 4.1.10.2.6_GAOvvw123 4.1.10.2.7_GAOvvw323 4.1.10.2.8_GAOvvw423 4.1.10.2.9_GAOvvw523 4.1.10.2.10_GCPrcess	1. 6/19/2023 2. January 2023 to current.	The following documentation supports the MCP's efforts to correct this finding: **MONITORING AND OVERSIGHT** » Desk Level Process, "Grievance and Appeal Audit Process" (07/23) demonstrates the Plan has an audit process to verify if QOS/QOC grievances (4.1.10.2 Audit DLP) The Plan's goal is to audit a total of 30 case files each quarter with a 90% or above passing score. Grievance Coordinator (GC) Leads will randomly audit a total of 10 audits on a monthly basis to support the quarterly goal. If less than 90% on monthly audit, the GC Lead will address areas of deficiency and corrections. If repeat deficiencies are noted in one or more areas during three consecutive audits, in addition to correcting the area of deficiency, the Grievance Coordinator (GC) will be required to meet 1:1 with a Supervisor, GC Lead, or their designee and/or additional training will be required. (4.1.10.2 Audit DLP) » Report, "GA Closed Report" (06/23) demonstrates the Plan has created a report during the reporting period that identified grievances noted in the core information system that were closed without being assigned to the Grievance team. This report is reviewed daily. (4.1.10.2 DLP GA Rpt) and (4.1.10.1_GACLOSEDRpt)

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				» Modified Report, "GA Closed Report" (09/23) The Plan added additional call codes from their core information system to the GA Closed Report. By adding more call codes that MSRs use every day, it allows the Plan to search and identify more member dissatisfactions that may not have been assigned to the Grievance Coordinators on a daily basis. (4.1.10_Changes to GAClsdRpt) **TRAINING** » Meetings, "Grievance and Appeal Team Meetings" (01/25/23, 03/29/23, 04/26/23, and 05/24/23) and "New Hire Orientation" (01/25/23, 03/08/23, 04/27/23, and 05/31/23) demonstrates the Plan conducted Grievance and Appeal monthly staff meetings and new hire orientations in regard to complaint and a dissatisfaction is formally known as a Grievance. (4.1.10.2.1_Agnd12523, 4.1.10.2.2_Agnd22223, 4.1.10.2.3_Agnd32923, 4.1.10.2.4_Agnd42623, 4.1.10.2.5_Agnd52423, 4.1.10.2.6_GAOvvw123, 4.1.10.2.7_GAOvvw323, 4.1.10.2.8_GAOvvw423, 4.1.10.2.9_GAOvvw523, and 4.1.10.2.10_GCPrcess) If the member is dissatisfied with a provider and/or the Plan, staff is required to document detailed information of member's complaint. GA staff are required to process all dissatisfactions as grievances.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				The corrective action plan for finding 4.1.10 is accepted.
4.2.1 Monitoring of Linguistic Performance The Plan did not assess the linguistic performance of bilingual employees and contracted staff who provide linguistic services.	1. KHS' post call survey evaluates member's call experience by language. Two (2) additional survey questions have been added to evaluate the linguistic performance of the staff. The results are reported on a monthly basis by language. 2. 10 Spanish member calls will be audited on a monthly basis by the C&L team and reported quarterly. 3. An interpreter satisfaction survey will be sent to all members who used KHS' direct and contracted interpreting services to evaluate their experience. Survey results will be reported on a quarterly basis. 4. KHS' phone interpreter vendor will send a quarterly call audit report. 5. Monitoring results on the linguistic performance of staff and contracted	1. 4.2.1.1_323PCSRsults 2. 4.2.1.2.1_SpCallTool 4.2.1.2.2_SpCallTrck 3. 4.2.1.3_InterpSurvey 4. Vendor call audit report will be delivered by the end of July and then quarterly afterwards. 5. 4.2.1.5_CLMonitorWF	1. June 2023 2. June 2023 3. June 2023 4. July 2023 5. July 2023	The following documentation supports the MCP's efforts to correct this finding: **MONITORING AND OVERSIGHT** » Post Call survey was updated to include two questions to evaluate the linguistic performance of staff. Questions were regarding speech clarity and understandability. » Audit template and results from May 2023 demonstrate the MCP is conducting audits of its calls to monitor performance. » Interpreter evaluation form which is sent to all members who use both MCP and contracted interpreting services to evaluate experience with the interpreter. » Vendor audit materials demonstrate the MCP's phone interpreter vendor audits the skills and performance of its staff and reports results back to the MCP. » Monitoring Linguistic Performance of KHS Bilingual Staff, Interpreters and Vendors workflow shows how each of the five methods of monitoring of linguistics performance is shared on a quarterly basis quarterly compliance meetings. **The corrective action plan for finding 4.2.1 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	interpreters will be shared during the KHS quarterly Compliance meetings.			
4.3.1 PHI Breach Notification to DHCS The Plan did not submit PIR forms to the required DHCS contacts within the required timeframe.	1. Updated HIPAA Log to track/report on timeliness 2. Created visio workflow 3. Obtained clarification on appropriate notification to all required parties through online portal 4. Created job aid for online reporting 5. Scheduled weekly meetings to monitor status 6. Reviewed reporting timelines and requirements in weekly Compliance team meeting 7. Reporting timeliness will be presented in Compliance Committee meetings moving forward (beginning with July Committee Meeting)	1. 4.3.1.1_LogSample 2. 4.3.1.2_Workflow 3. 4.3.1.3_PIR Email 4. 4.3.1.4_PIR Job Aid 5. 4.3.1.5_WklyMtng 6. 4.3.1.6_Agenda 7. Compliance Committee Reporting	1. 6/12/2023 2. 6/1/2023 3. 6/2/2023 4. 6/5/2023 5. 2/9/2023 6. 6/1/2023 7. 7/23/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » The Plan revised and implemented policies and procedures to demonstrate notifications and PIRs are sent to all required DHCS contacts within required timeframes. **MONITORING AND OVERSIGHT** » The Plan updated their HIPAA Log ("4.3.1.1_Log Sample") to include the required notification dates with due date columns. The tracker is monitored on a weekly basis in scheduled Compliance Department Team meetings. » The Plan's Compliance Department Team Meeting Agenda demonstrates that review of HIPAA Reporting Requirements is listed as agenda item number 5 (4.3.1.6_Agenda). » The Plan demonstrated current Q3 results that post-corrective action plan implementation is effective (4.3.1 & 4.3.2_CompComm).

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				» The Plan has communicated and verified with DHCS Contract Manager on the appropriate notification procedures to all required parties via the online portal (4.3.1.3_PIR Email). **TRAINING** » The Plan created a visual workflow for Plan staff as a guide to follow for timely reporting to DHCS, Unauthorized PHI Disclosure & Security Incident DHCS Reporting Process ("4.3.1.2_Workflow") in accordance with Plan policy *14.03-I PHI – Privacy, Use, and Disclosure* (revised 04/01/22). » Implementation of Job Aid-Reporting a Privacy Incident to DHCS ("4.3.1.4_PIR Job Aid") which instructs staff to send reports to all three required DHCS personnel through the DHCS breach reporting portal within the required timeframes. **The corrective action plan for finding 4.3.1 is accepted.**
4.3.2 Notification of Security Incident and Unauthorized Disclosure of PHI The Plan did not notify any DHCS contacts nor submit any PIRs upon the	1. Updated HIPAA Log to track/report on timeliness 2. Created visio workflow 3. Obtained clarification on appropriate notification to all required parties through online portal	1. 4.3.2.1_Log Sample 2. 4.3.2.2_Workflow 3. 4.3.2.3_PIR Email 4. 4.3.2.4_PIR Job Aid 5. 4.3.2.5_WklyMtng 6. 4.3.2.6_Agenda	1. 6/12/2023 2. 6/1/2023 3. 6/2/2023 4. 6/5/2023 5. 2/9/2023 6. 6/1/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » The Plan revised and implemented policies and procedures to demonstrate notifications and PIRs are sent to all required DHCS contacts within required timeframes. **MONITORING AND OVERSIGHT**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
discovery of unauthorized disclosures of PHI or security incident.	4. Created job aid for online reporting 5. Scheduled weekly meetings to monitor status 6. Reviewed reporting timelines and requirements in weekly Compliance team meeting 7. Reporting timeliness will be presented in Compliance Committee meetings moving forward (beginning with July Committee Meeting)	7. Compliance Committee Reporting	7. 7/23/2023	» The Plan updated their HIPAA Log ("4.3.1.1_Log Sample") to include the required notification dates with due date columns. The tracker is monitored on a weekly basis in scheduled Compliance Department Team meetings. » The Plan's Compliance Department Team Meeting Agenda demonstrates that review of HIPAA Reporting Requirements is listed as agenda item number 5 (4.3.1.6_Agenda). » The Plan demonstrated Q3 results (2023, Reporting Period: 07/01/2023 - 09/30/2023) that post-corrective action plan implementation is effective (4.3.1 & 4.3.2_CompComm). » The Plan has communicated with and verified that DHCS ISO and Privacy Officer automatically receive copies of all PIRs submitted via the online portal; therefore, the Plan's reporting obligations are fulfilled by submission to the portal (4.3.2.5_DHCS Response). **TRAINING** » The Plan created a visual workflow for Plan staff as a guide to follow for timely reporting to DHCS, Unauthorized PHI Disclosure & Security Incident DHCS Reporting Process ("4.3.1.2_Workflow") in accordance with Plan policy *14.03-I PHI – Privacy, Use, and Disclosure* (revised 04/01/22). » Implementation of Job Aid-Reporting a Privacy Incident to DHCS ("4.3.1.4_PIR Job Aid") which instructs staff to send reports to all

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				three required DHCS personnel through the DHCS breach reporting portal within the required timeframes. **The corrective action plan for finding 4.3.2 is accepted.**

5. Quality Management

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
5.2.1 Ownership Disclosure of Subcontractors The Plan did not collect and review ownership and control disclosure information of its subcontractors.	1. Updated Business Ownership and Disclosure (updated form to comply with APL 23-00 and 2024 DHCS Contract) 2. Obtained Ownership & Disclosure forms from the three of five credentialing delegates and from the delegate whose form was previously incomplete (Kaiser) 3. Delegate, USC, has declined to provide document; seeking guidance from DHCS and will provide update once response received. 4. Remaining delegate, UCLA, pending 5. Created new policy, which includes requirements for Ownership & Disclosure forms	1. 5.2.1.1_OwnDisc 2. 5.2.1.2.1_Kaiser 5.2.1.2.2_ConferMED 5.2.1.2.3_VCHChildNt 5.2.1.2.4_CHLA 3. 5.2.1.3_DHCSEmail 4. Contact out of office; reached out to additional contacts for completion of disclosure document – will be provided upon receipt 5. 5.2.1.5_14.59-P	1. 5/26/2023 2. 5/26/2023 5/31/2023 6/2/2023 6/8/2023 3. 6/2/2023 4. 6/23/2023 5.3 Upon DHCS approval of policy (estimated July 2023)	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Plan submitted revised Policy 14.59-P Conflict of Interest Avoidance Policy (5/24/23). The Plan will collect and review subcontractor ownership and control disclosures as set forth in CFR 455.104. Disclosures will include persons with an ownership or control interest, as well as, managing employees. **MONITORING AND OVERSIGHT** » Plan has developed a subcontractor ownership and control disclosure form to use when requesting required information. **TECHNICAL ASSISTANCE** » Plan is no longer required to submit any ownership and disclosure information containing Personally Identifiable Information (PII) to DHCS as part of the Corrective Action Plan (CAP). The Plan must continue to ensure subcontractors accurately provide all required information in their disclosures. Additionally, the Plan must review disclosure forms to identify potential conflicts of interest and make subcontractor ownership and control disclosures available upon request, as the information is subject to audit by DHCS.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				The corrective action plan for finding 5.2.1 is accepted.
5.2.2 Monitoring of Delegated Entities The Plan did not consistently conduct monitoring and evaluation of the credentialing functions delegated to subcontractors.	1. VSP Audit has been conducted and process updated going forward. 2. Audit of Kaiser credentialing functions will be audited in upcoming audit	1. 5.2.2.1.1_VSPAudit 5.2.2.1.2_VSPResults 2. 5.2.2.2_KPAudit	1. 1/4/2023 2. August 2023	MCP's root cause identified that Vision Service Plan's (VSP) multi-departmental delegation was inadvertently not scheduled for an annual audit for calendar year 2022. This prompted Kern's PNM Department's internal auditing process, for annual credentialing oversight, to be reorganized under the PNM's Credentialing Annual Audit Reporting Calendar to confirm the annual delegated credentialing audit is conducted timely and consistently each calendar year. The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Established Policy 4.32-P Delegated Credentialing requires prior to delegation and annually audits of delegate's applicable credentialing activities, quality assurance policies and procedures and established criteria. **MONITORING AND OVERSIGHT** *The Vision Service Plan's (VSP) audit has been conducted on 1/4/23 after inadvertently not being scheduled; scheduling processes have been updated.* » "VSPAudit", "VSPResults" – Vision Services Plan Audit & Results

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				» Plan conducted audit on their Vision Service delegate, finalized on 1/20/23 » Audit results revealed a 100% overall score » "KPAudit" - future audit (September 2023) » Plan will be conducting annual oversight audit of Kaiser. Audit letter outlines list of documents/ materials requested per audit category. **The corrective action plan for finding 5.2.2 is accepted.**
5.3.1 New Network Provider Training The Plan did not document provider trainings were completed within ten working days of newly contracted providers being placed on active status.	1. Policy updated to capture training documentation processes 2. Orientation Documentation Tool (ODT) Updated 3. Orientation Documentation Tool Implemented	1. 5.3.1.1_4.23-P 2. 5.3.1.2_ODT 3. 5.3.1.3_ODTxmpl	1. 6/1/2023 2. 6/1/2023 3. 6/1/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Plan Policy 4.23-P Provider Education provides an overview of provider training requirements, procedures for conducting provider training, curriculum, and additional training offerings. » Training will be conducted for all contracted providers and their staff within 10 business days of being placed on active status. Providers will be informed that they may not provide services to Plan members until the provider completes training. » Training can be conducted one-on-one or in group settings. It may be conducted online or in-person.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				» Attendees will be required to sign-off verifying attendance and will include the attendees name, title, and signature/date. The Plan will maintain records of attendance for all trainings. Provider Relations Representatives will be responsible for tracking and monitoring the completion of initial trainings, collecting sign-off and ensuring trainings are conducted within the required timeframe. **MONITORING AND OVERSIGHT** » Provider In-Service Sign-In Sheet (template) which includes provider name, date of service, and attendee signature and date. » Provider In-Service Sign-In Sheet (example) that identifies the provider, date of training and signature and date of attendees. » Plan provided evidence that new provider training is being tracked and monitored to confirm timeliness requirements are being met. August provider training report tracks new contract effective date, provider orientation date, and also included signed proof of orientation. **The corrective action plan for finding 5.3.1 is accepted.**
5.3.2 Delegation Requirements	1. Policy Updated with KHS Delegation Language	1. 5.3.2.1_KHS_4.23-P 2. 5.3.2.2.1_KHS_KPAtt 5.3.2.2.2_KHS_VSPAtt	1. 6/1/2023 2. 6/2/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
The Plan did not have written agreements addressing the provision and oversight of delegated new provider training responsibilities.	2. Plan created provider training attestations and sent to delegated entities (pending receipt of signed attestation 3. Delegation Oversight Policy updated	3. 5.3.2.3_14.55	3. Upon DHCS approval (estimated July 2023)	Policy 14.55-P Delegation Oversight (6/14/23) » Plan will oversee and remain accountable for any services or functions undertaken by a Subcontractor. Plan may enter into agreements with entities to fulfill its obligations and duties under the contract. Plan will include all duties and obligations and reporting relating to the delegated duties in the subcontractor agreement. » Plan will maintain effective oversight to confirm Subcontractors compliance with all delegated activities. Plan will regularly monitor all functional areas delegated to Subcontractors and confirm Subcontractors follow the subcontractor agreement and regulatory requirements. Plan receives reporting from delegated entities as established in each entity's delegation Agreement. » Plan will conduct focused or full scope audits of Subcontractors to assess compliance with requirements relevant to the delegated functions, including provider training. 1. A copy of the organization's Provider Manual 2. A copy of the organization's provider training policies and records for the audit period, including:

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				» Policies and Procedures regarding provider training and onboarding. » Materials used for provider training and onboarding during the audit period. » A list of all newly contracted providers during the audit period. Separate providers by specialty and include the date the provider became active with the Plan, and the date in which the new provider training took place. » A list of other provider training which took place during the audit period, including dates, topics discuss, attendees. **MONITORING AND OVERSIGHT** » Provider Training attestations (5.3.2.2.3 Kaiser Att. and 5.3.2.2.4 VSP Attest.) for impacted delegates. Both attestations were executed on 6/8/23 and indicate provider training will be conducted for all participating providers, including the timeframe, and how training may be conducted. Evidence of completed training will be made available to be reviewed as part of Plan's delegation oversight audits. » Plan is currently working on a new contract with VSP, expected by 12/31/23 which will specify VSP's contractual responsibilities, including provider training. In the meantime, the Plan submitted an executed amendment adding language about provider training to the Vision Care Agreement effective

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				10/1/23 (three months). This will allow the Plan to negotiate and execute an updated professional services agreement with VSP. The amendment requires VSP to continue to assume responsibility for the training of providers in strict adherence to the guidelines outlined in the DHCS contract (5.3.2 VSP Amendment). **The corrective action plan for finding 5.3.2 is accepted.**

6. Administrative and Organizational Capacity

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
6.1.1 Monitoring of Health Education Services The Plan did not conduct appropriate levels of program evaluation nor monitor performance of providers of health education services.	1. An audit tool has been developed to evaluate health education class service delivery. 2. Member pre and post knowledge surveys are administered during a class series and will be reported in the Health Education quarterly activities report. 3. Member evaluation surveys will be collected from members who received services through KHS or a contracted health education provider. The results of the survey will be reported in the Health Education quarterly activities report. 4. Trending reports on routine prenatal care are used to evaluate the Baby Steps pregnancy education program.	1. 6.1.1.1.1_HEDAudTool 6.1.1.1.2_HEDMonWF 2. 6.1.1.2.1_HEALTests 6.1.1.2.2_AsthmaTest 6.1.1.2.3_FreshStart 6.1.1.2.4_DPPPPTest 3. 6.1.1.3.1_AsthmaEval 6.1.1.3.2_AsthmaEval 6.1.1.3.3_FreshStart 6.1.1.3.4_HEALEval 6.1.1.3.5_HEDSvcEval 6.1.1.3.6_DPPEval 4. 6.1.1.4_PrenataComp	1. May 2023 2. April 2023 3. April 2023 4. April 2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Policy 11.24-I Health Education outlines delivery of evidence-based health education programs using educational strategies appropriate for member population. » Plan monitors performance of health education program through review of member grievances, member satisfaction surveys, pre/post knowledge surveys and class facilitator audits. **MONITORING AND OVERSIGHT** » Plan submitted sample Health Education Service Audit Tool (6.1.1.1.1 Audit Tool) and program evaluation/monitoring workflow (6.1.1.1.2 WF). » Plan submitted Q2 audit scores and narrative outlining scoring methodology. Results included identifying opportunities for growth. » Plan submitted examples of various health education pre/post knowledge questionnaires covering healthy eating and lifestyle, asthma, smoking and diabetes prevention.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				» Samples of class participation evaluations (Eval Fnd Q2) included participant ratings of materials, presentation, facilitator, and satisfaction/recommendations. **The corrective action plan for finding 6.1.1 is accepted.**

SSS. State Supported Services

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
SSS.1 Claim Denial The Plan improperly denied a state supported services claim.	1. Retraining of claims processors	1. SSS.1.1.1_ATTEND_LOG SSS.1.1.2_TRAIN_DOCS	1. 5/31/2023 6/1/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Desktop Procedure, "Claim Denial" (07/17/23) to demonstrate that SSS claims should never be denied because the provider is out of network. Also, never deny for authorization, even if the code shows as authorization is required. (CLM Denial). **MONITORING AND OVERSIGHT** » "Family Planning and Sensitive Services Audit Report" (07/13/23) to demonstrate that the MCP has a monitoring process to review claims that were denied. The MCP's Senior Examiner/Auditor will review the report and pend any claims that are denying inappropriately to be reworked before final adjudication. The report is processed each day and those that should not deny are corrected. (FP_SSS_RPT2). **TRAINING** » Training Slides, "Paper EOB Review Retraining" and attendance log (05/31/23) to demonstrate that the MCP's claims staff received retraining on reading Primary EOBs. (Train Docs, Attend Log). **The corrective action plan for finding SSS.1 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
SSS. 2 Interest Payment and Late Fee The Plan did not pay interest and late fee for state supported services claims processed beyond 45 working days.	1. Retraining of claims processors	1. SSS.2.1.1_INT_DOCS SSS.2.1.2_ATTEND_LOG	1. 5/31/23 6/1/23	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » P&P, "60.05-I: Payment of Interest on Late Claims" which states that payments for all other complete claims shall automatically include interest at the rate of 15 percent per annum for the period of time that the payment is late beginning with the first calendar day following the 45th working day. **MONITORING AND OVERSIGHT** » Monitoring Reports, "Non Paid Claim List for Claims Over 28 Calendar Days Old," "Claims Monthly Key Performance Indicators," and "Disputes Turnaround Time" to demonstrate that the MCP has a monitoring process to track SSS claims processed beyond 45 working to confirm that interest and late fees were paid. All claims are monitored to confirm claims are paid within the timeframes. The report, "Non Paid Claim List for Claims Over 28 Calendar Days Old" tracks all claims over 28 calendar days that were not paid or denied. The report, "Claims Monthly Key Performance Indicators," tracks all claims paid or denied in the month and the monthly timeliness percentages. The report, "Disputes Turnaround Time" is reviewed by the MCP's Dispute Supervisor to ensure all disputes are completed within the

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				required 45 working day timeframe. (All Claims Over 28 Days, Disputes TAT, Paid Claim Timely.) **TRAINING** » Training Slides, "Dispute Review Process Training Document" and attendance log (05/31/23) to demonstrate the MCP's claims staff received retraining on how interest is applied and when it is required. (INT_DOCS). **The corrective action plan for finding SSS.2 is accepted.**

*Attachment A must be signed by the MCP's compliance officer and the executive officer(s) responsible for the area(s) subject to the CAP.

Submitted by: __ Deborah Murr, RN, CCO, Kern Health Systems

Title: ___ Chief Compliance and Fraud Prevention Officer

Signed by: _[Signature on file]_

Date: ___06/08/2023_