DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

June 27, 2024

Julie Bomgren
Director, Medi-Cal Policy
KP Cal, LLC
1800 Harrison St.
Oakland, CA 94612

Via E-mail

RE: Department of Health Care Services Medical Audit

Dear Ms. Bomgren:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of KP Cal, LLC, a Managed Care Plan (MCP), from October 31, 2022 through November 10, 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. 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]

Dana Durham, Chief
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

cc: Stacy Nguyen, Chief — Via E-mail
Managed Care Monitoring Branch
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

Grace McGeough, Chief — Via E-mail
Process Compliance Section
Managed Care Monitoring Branch
DHCS - Managed Care Quality & Monitoring Division (MCQMD)

Lyubov Poonka, Chief — Via E-mail
Audit Monitoring Unit
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Mike Pank, Lead Analyst — Via E-mail
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DHCS - Managed Care Quality & Monitoring Division (MCQMD)

Aldo Flores, Unit Chief — Via E-mail
Managed Care Contract Oversight Branch
DHCS – Managed Care Operations Division (MCOD)

Jalen Yip, Contract Manager — Via E-mail
Managed Care Contract Oversight Branch
DHCS – Managed Care Operations Division (MCOD)

ATTACHMENT A
Corrective Action Plan Response Form

Plan: KP Cal, LLC dba Kaiser Permanente
Audit Type: Medical Audit

Review Period: 11/1/21 – 10/31/22
CAP Submitted: 04/26/2023

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
1.2.1 - Prior Authorization Decision Timeframes: The Plan did not render decisions for routine prior authorization approvals within the required 14-calendar day timeframe.	The Plan will update the DME workflow document to ensure that rendering decisions for routine DME prior authorizations are completed within the required 14 calendar day timeframe. The workflow will allow requests to be denied when the DME department receives referrals that have insufficient information to process. Updates to the workflow will entail collaborating with multiple UM partners (NCAL DME, SCAL DME, UM North and UM South). By end of Q2 2023, defined denial language letter inserts will be finalized. System enhancements and training of staff will be completed by Q4 2023.		Q2 2023 Q2 2023 Q4 2023	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • Revised desk level procedure, "DME Oversight of Utilization Management Process for Medi-Cal Referrals" (6/15/23) outlines regulatory requirements; routine decisions are required to be made within 5 working days of receipt of information needed to make a determination, but no later than 14 days for both authorizations and denials. (2. NCAL DLP - DME Oversight of the UM Process for Medi-Cal Managed Care Referrals v6.15.2023) o DME RN Supervisor monitors Medi-Cal referrals through the Tapestry Work queue at the start and end of every shift to identify unprocessed/pending referrals. Applicable referrals are then assigned to a DME clerk for review and processing. o Weekly random audits are conducted to verify regulatory compliance. Findings are rectified and education and/or modification to processes are completed as needed. **MONITORING AND OVERSIGHT**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
			Q4 2023	• Plan implemented an escalation process as of 8/18/23 (Attachment 3) which includes weekly audits to demonstrate the Plan is meeting timeliness requirements. (3. DLP - Medi-Cal Order Measures for Mitigation) • Weekly audits started 8/18/23 (Attachment 4). Sample report provides a 30-day data extract for GMC Sacramento DME Medi-Cal prior authorizations processed between the dates 8/22/23-9/20/23. Column I in the data extract indicates the time from physician signature to time of order processing completion. Processing time did not exceed the 14-day timeframe for the period above. (4. Referrals Processed 8.22.23-9.20.23 v1) **The corrective action plan for finding 1.2.1 is accepted.**
1.2.2 - Prior Authorization Delay Notices: The Plan did not notify both its requesting providers and its members of their intent to extend the processing time for routine prior authorization cases	The Plan will review and update existing workflows and develop technical system solutions to provide delay notifications to both the requesting provider and the member when routine prior authorization case processing is expected to go beyond the 14-calendar day timeframe. This will take significant IT development work to enable notifications to be sent		Q4 2023	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • Plan submitted revised policy, "17.0: UM Denial of Practitioner Requested Services" which reflects requirement to notify both members and providers when a determination cannot be made within the required timeframe. (5. RM_UM PP 17.0 UM Denial of Practitioner Requested Services Final (1), pp. 10, 32-33).

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beyond the initial 14 calendar timeframe.	to both members and providers.			**MONITORING AND OVERSIGHT** • Plan submitted a sample report that demonstrates monitoring of aging, unprocessed DME referrals. Plan reviews each weekday to identify/prioritize referrals to be processed timely. (4. Referrals Processed 8.22.23-9.20.23 v1) In addition, Plan identified an automated solution for sending delay notification letters and the needed technical system changes to pull appropriate data and populate the letter templates. The Plan submitted narrative outlining technical buildout milestones, including testing and validation. Production implementation on target for 11/15/23. (1. Completed DHCS Narrative 1.2.1 and 1.2.2_v9.24.23) **The corrective action plan for finding 1.2.2 is accepted.**
1.2.3 - Language Assistance Taglines: The Plan did not include updated LAT information in prior authorization notices sent to members in accordance with APL 21-004.	DME Department Updated letter template requirements were discussed with KP IT Teams. The Plan confirmed that the letters were updated with the appropriate taglines on April 22, 2022. Letters issued to members prior to April 22, 2022, did not have the updated taglines. All letters issued from April 22, 2022,		April 22, 2022	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** The Plan discussed the updated LAT letter templates with internal IT teams and the referral unit (KP Health Connect), which added the updated LAT with Ukrainian and Mein languages in prior authorization notices.

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	forward are compliant.
	
	<u>TPMG Referral Operations:</u>
	The Plan initiated a request to KP Health Connect (KPHC) to add the updated language assistance taglines, Mien and Ukrainian, to prior authorization member notices in accordance with APL 21-004. Target completion is May 26, 2023.
			May 26, 2023	**MONITORING AND OVERSIGHT**
				
				• "DHCS Tagline Example After 4.22.22 Case 2"
				  ○ The Plan submitted a template prior authorization letter with the most updated LAT with Ukrainian and Mein languages (pages 5, 6)
				
				• "Medi_Cal Updated Patient Letter Template_No_PHI"
				  ○ The Plan submitted a template prior authorization letter from the Plan's referral operations unit with the most updated LAT with Ukrainian and Mein languages (pages 6, 7)
				
				The corrective action plan for finding 1.2.3 is accepted.

1.2.4 - Utilization Management Criteria for Dental Anesthesia: The Plan denied general anesthesia for dental services using UM criteria that were more restrictive than Medi-Cal guidelines	The Plan revised UM criteria for Dental Anesthesia to align with APL 15-012. Criteria was approved by the Utilization Management Steering Committee (UMSC) on November 21, 2022, so as not to be more restrictive than Medi-Cal guidelines. The dental anesthesia form was revised and distributed to all Outside Referral Department (ORD) staff.	1.2.4 SCAL 2022 DA UM Criteria Clean and Redline Copy 1.2.4 DA UMSC Minutes showing approval of the revisions	November 21, 2022	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated P&P, "2022 Utilization Management (UM) Criteria for Dental Anesthesia – Medi-Cal" (11/21/22) which demonstrates that the policy was updated to align with APL 15-012. The more restrictive "Clinical Review Criteria" was removed from the policy. This was approved by the Utilization Management Steering Committee

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described in APL 15-012.	Training to providers and staff on the revised dental anesthesia criteria occurred on December 8, 2022.	1.2.4 Dental Anesth (DA) Request Form 1.2.4 ORD UM External Training Deck 12.08.2022 1.2.4 ORD UM External Training 12.08.2022.Invite	December 12, 2022 December 8, 2022	(UMSC) on November 21, 2022. (SCAL- 2022 Dental Anesthesia_UM Criteria_Medi-Cal Clean Final 11.22). • "Regional Utilization Compliance (RUC) department Workflow" (04/11/23) which demonstrates that the MCP reviews denied cases prior to finalization of member and provider written notifications. The review includes accurate citation and appropriate application of criteria to verify that decisions are made correctly. (UM Denial Workflow). **TRAINING** • PowerPoint Presentation, "UM External Authorization" (12/08/22) which demonstrates that training to providers and staff on the revised dental anesthesia criteria was conducted. (ORD UM External Training Deck 12.08.2022 FINAL). **MONITORING AND OVERSIGHT** • Audit Tool, "RN Audit Tool" and outcome of audit results, "UM RN to RN Letter Review" to demonstrate that the MCP has a monitoring process to review denied cases prior to finalization of member and provider written notifications. The audit categories include "Correct Application of Criteria Based on Denial Rationale" and "Criteria citation: Description of the criteria on which the decision is based."

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				The audits are conducted on a weekly basis, ensuring regular and consistent oversight. (Database 1 – 5, UM RN to RN Letter Review). **The Corrective Action Plan for Finding 1.2.4 is accepted.**
1.2.5 - Explicit Clinical Reason in NOA Letters: The Plan did not explicitly state how the member's condition did not meet criteria and did not provide clinical reasons for decisions within NOA letters for adverse benefit determinations based on medical necessity.	The Plan revised the UM denial workflow to include review of requested services/items for possible application of EPSDT guidelines. DME EPSDT denial inserts/rationale were revised to include the EPSDT guideline and the clinical criteria for the requested item. This will be included in the physician reviewer's documentation along with the EPSDT criteria. Regional Utilization Committee Team does the final review of all denial letters to ensure all required elements are in the letter. Revised EPSDT denial inserts/criteria will be submitted to the System Solution and Deployment SSD/Tapestry team by June 21, 2023.	1.2.5 Clin Reason NOA letters – UM Denial Workflow 1.2.5 UM Denial Workflow 1.2.5 Letter documentation training	April 11, 2023 June 21, 2023 February 22, 2023	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • UM Denial Workflow / Clinical Reason NOA Letter UM Denial Workflow updated to include review of authorization requests for Possible application of EPSDT guidelines. (1.2.5 Clin Reason NOA ltrs -UM Denial Workflow -4-11-23 ian.) **TRAINING** • Training documentation for Regional Utilization Compliance Team directs staff to explain how members' condition does not meet the clinical criteria or guidelines. (1.2.5 Letter Documentation Training 2/22/23) • Email dated 6/28/23 demonstrates revised EPSDT denial inserts/criteria have been submitted to the System Solution and

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	Denial letter training provided to Regional Utilization Compliance (RUC) team.			Deployment SSD/Tapestry and are live as of 6/28/23. (1.2.5_EPSDT Live) **MONITORING AND OVERSIGHT** • Completed RN Auditing Tool demonstrates weekly monitoring of RUC Team NOA letters for the presence of clinical reasons for the decisions is occurring. (1.2.5- UM RN to RN Letter Review) **The corrective action plan for finding 1.2.5 is accepted.**
1.2.6 - Translation of Authorization Letters: The Plan did not provide translated written member information for authorization notices to members whose primary language was an identified threshold language.	The Plan is implementing the following actions to ensure written member authorization notices are sent to members in their primary identified threshold language: 1. The Plan created an easily searchable external database to store member preferred primary. 2. The Plan will provide training on use of database for daily workflow. 3. The Plan will provide additional training on APL17-011 and APL 21-004 to the San Diego GMC Utilization Management Team.	1.2.6 Sac-SD Quality Translation Process for Member Informing Materials	January 30, 2023 May 30, 2023 May 30, 2023	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • Plan policy "Quality Translation Process for Member Informing Materials" was submitted & approved by DHCS MCOD June 2023. The updates demonstrate the Plan's process & the requirements followed when translating written member information for authorization notices to members whose primary language is an identified threshold language. (Pages 1-2 & page 7) **MONITORING AND OVERSIGHT**

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	4. The Plan will create report for ongoing monitoring to reconcile translation requests sent to the vendor versus what is in the San Diego GMC Utilization Management Team-work basket. The Plan is also resubmitting policy: Quality Translation Process for Member Informing Materials (APL 21-004) to demonstrate compliance with the APL requirements for a policy. The policy was in place during the 2022 audit review period.		May 30, 2023 November 1, 2022	• The "Language Monitoring Report" demonstrates the Plan's daily tracking & monitoring process that identifies communications that required translation & whether that was completed. This process allows the Plan to reconcile translation requests sent to the vendor. **TRAINING** • The "Outside Referral Department (ORD) Monthly Managers' Meeting Agenda" & the "Medi-Cal Data Repository (MCDR) Training" demonstrates the Plan provided training on the use of its database for daily workflow with translation services. **The corrective action plan for finding 1.2.6 is accepted.**
1.2.7 - Consistent Application of Criteria: The Plan did not ensure that written criteria or guidelines used for utilization review were consistently applied.	The Plan will ensure an increase in the physician participation of Inter-rater reliability (IRR) testing for consistent application of criteria by revising the IRR process and leveraging existing technology as follows: • IRR testing and training will be placed on a physician portal that will change the training from one-		Q3 2023	The following documentation supports the Plan's efforts to correct this finding: **TRAINING** • SCAL Annual External Authorization Training Certificate demonstrates the MCP's virtual training is operational. (1.2.7_SCAL Annual External Training)

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	live training session to a virtual training session which will allow the physicians to have increased flexibility for taking the training based on their own schedule, cadence, and availability. This will also allow them to engage in refresher training as needed. Meetings have occurred and will continue to occur to revise the IRR testing and training deck and implement the structural changes to the IRR training by Q3 2023.			**MONITORING AND OVERSIGHT** • The Plan addresses the tracking and monitoring of physicians by having the training and IRR in the physician portal system. System can provide reports to determine who has and who hasn't completed training and IRR. System has a task monitor which serves as visual reminder that tasks to be completed. • IRR Status Report from 8/22/23 monitors providers participation in the IRR testing initiative. reports are be produced to monitor the progress and completion of the training and IRR testing. Reminder emails will also be sent to decision makers who have not completed the task. (1.2.7 Course Full Status Report Revised - 8.22.2023) **The corrective action plan for finding 1.2.7 is accepted.**
1.3.1 - Appeals Decision Timeframes: The Plan did not resolve standard and expedited prior authorization appeals	The Plan hired additional staff in 2022 to support the increased volume and continue to evaluate staffing resources to improve timeliness. The Plan is actively working to address these concerns and minimize the impact to our members. Specifically, we have a		2022 and ongoing as needed	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • "CA Non-Medicare G&A Policy_CAP Updates_redline". Section 6.7.4 of the CA Non-Medicare Grievances and Appeals (G&A) Policy

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
within the required 30 calendar day and 72-hour timeframes, respectively.	coordinated effort across our three entities (health plan, hospital, and medical group) to improve the member and patient experience and reduce overall grievance and appeal volumes. Hiring efforts will continue this year to ensure we have staffing to meet member demand. Meetings held to review timeliness requirements with staff and make them aware of the finding.	Staff meeting presentation Staff meeting sign-in sheets	April 19, 2023, and April 26, 2023	confirms standard and expedited appeals must be resolved within 30 calendar days and 72 hours, respectively. An update to the policy was not needed since the appeal resolution timeframes have not been changed since the last effective date listed, February 28, 2022. **OVERSIGHT AND MONITORING** • "1.3.1_Sample METRS View". The Plan has a system in place, METRS, which generates the regulatory activities that need to be completed (i.e. acknowledgement, resolution), each with their own regulatory timeframe. The Plan staff then reference these activities and their respective timeframes to demonstrate their assigned tasks are completed by the required timeframe. This also enables operational managers to have daily oversight of appeals due and reinforce timeliness in real time. • "1.3.1_Internal Monitoring Results" shows timeliness scores from the Plan's quarterly internal monitoring program from 4Q22 through 2Q23. The Plan's management team has increased methods of oversight with the development of a daily report derived from data in the KPI dashboards that flags cases coming due. This allows managers to take more proactive measures to remove barriers that may result in untimeliness. In 2Q23 and 3Q23, additional staff were hired to address overall increased volume trends, which will continue

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				to support more improvements in timeliness as staff are fully onboarded and trained. **TRAINING** • "1.3.1_Appeal Resolution Training". The Plan's training is used for all regions Program-wide and all non-Medicare lines of business. Lesson 4 (page 17) of the Resolution training details the appeal resolution timeframes for Medi-Cal. **The corrective action plan for finding 1.3.1 is accepted.**
1.3.2 - Language Assistance Taglines for Appeals: The Plan did not send updated LAT information in accordance with APL 21-004 for prior authorization appeal notices.	Since identifying this issue, the Plan corrected the configuration issue to ensure updated LAT information is used. This issue was resolved as of January 24, 2023.	Updated LAT	January 24, 2023	The following documentation supports the Plan's efforts to correct this finding: The Plan resolved a back-end configuration issue that led to outdated nondiscrimination notices (NDNs) and language assistance taglines (LATs) and is fully aware of the requirements outlined in APL 21-004. **POLICIES AND PROCEDURES** • "Updated LAT_1557 Non-Standard NOLA" o The Plan submitted an updated LAT document with recently added Ukrainian and Mein language translations (page 2, 3) **The corrective action plan for finding 1.3.2 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
1.5.1 SAC - Notice of Action "Your Rights" Attachment: The Plan did not ensure a delegate sent the updated NOA "Your Rights" Attachments to members for adverse benefit determinations in accordance with APL 21-011.	Health Plan Utilization Management (HPUM) updated the NCAL UM Policy 28.0 – Delegation of UM Activities for Delegated Entities and SCAL UM Policy 33.0 – Delegation of UM Activities to reflect proper process and procedure for communicating regulatory changes to the notification templates. The policies will be reviewed and approved by the UM Committees on April 25, 2023. American Specialty Health reviewed the Plans HPUM updated Policies and supporting documents at the ASH Corporate Compliance Committee (CCC) on April 4, 2023. CCC had no initial concerns based on the documents reviewed at the CCC meeting. ASH will work cooperatively with the Plan to meet our responsibilities in accordance with the DHCS audit. Once the Plan has a	1.5.1 NCAL RM UM P&P 28.0 KPNC Delegation of UM Activities for Delegated Entities	April 25, 2023 April 4, 2023	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • Plan Policy "28.0 KPNC Delegation of UM Activities for DEs" was updated to reflect the changes to the Plan's UM process for communicating regulatory changes to the UM delegate to demonstrate how the delegate should be notified of changes & distribute updated NOA "Your Rights" attachments to members for adverse benefit determinations. (6.0, page 3) **MONITORING AND OVERSIGHT** • Audit Report "ASH Audit Tool" demonstrates the Plan's quarterly monitoring process which the Plan conducts audits of the vendor's denial letters (NOA letters including all the attachments, NDN, LAT, appeal rights). The Plan began this process in June 2023 & will continue to conduct quarterly audits of its vendor. • The Plan's NOA "Your Rights" attachment is up to date & includes all necessary components. **The corrective action plan for finding 1.5.1 SAC is accepted.**

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	final/approved policy it will be shared with ASH. ASH will review and develop a plan to implement the changes within 30 days.		Within 30 days of policy approval notification by the Plan	
1.5.1 SD - Notice of Action "Your Rights" Attachment: The Plan did not ensure a delegate sent the updated NOA "Your Rights" Attachments to members for adverse benefit determinations in accordance with APL 21-011.	Health Plan Utilization Management (HPUM) updated the SCAL UM Policy 33.0 – Delegation of UM Activities to reflect proper process and procedure for communicating regulatory changes to the notification templates. The policies will be reviewed and approved by the UM Committees on April 24, 2023. American Specialty Health reviewed the Plans HPUM updated Policies and supporting documents at the ASH Corporate Compliance Committee (CCC) on April 4, 2023. CCC had no initial concerns based on the documents reviewed at the CCC meeting.	1.5.1 SC.RUM.033 - Delegation of UM Activities for Delegated Entities	April 24, 2023 April 4, 2023	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • Plan Policy "SC.RUM.033 Delegation of UM Activities for DEs" was updated to reflect the changes to the Plan's UM process for communicating regulatory changes to the UM delegate to demonstrate how the delegate should be notified of changes & distribute updated NOA "Your Rights" attachments to members for adverse benefit determinations. (5.5, page 4) **MONITORING AND OVERSIGHT** • Audit Report "ASH Audit Tool" demonstrates the Plan's quarterly monitoring process which the Plan conducts audits of the vendor's denial letters (NOA letters including all the attachments, NDN, LAT,

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	ASH will work cooperatively with the Plan to meet our responsibilities in accordance with the DHCS audit. Once the Plan has a final/approved policy it will be shared with ASH. ASH will review and develop a plan to implement the changes within 30 days.		Within 30 days of policy approval notification by Health Plan UM	appeal rights). The Plan began this process in June 2023 & will continue to conduct quarterly audits of its vendor. • The Plan's NOA "Your Rights" attachment is up to date & includes all necessary components. **The corrective action plan for finding 1.5.1 SD is accepted.**
1.5.2 SD - Translation of NOA Letter Packets: The Plan did not ensure a delegate provided immediate, full translation of written member information in the Notice of Action letter packet,	Health Plan Utilization Management (HPUM) updated SCAL UM Policy 33.0 – Delegation of UM Activities to reflect proper process and procedure for communicating regulatory changes to the notification templates. The policies will be reviewed and approved by the UM Committees on April 24, 2023.	1.5.2 SC.RUM.033 - Delegation of UM Activities for Delegated Entities	April 24, 2023	The following documentation supports the Plan's efforts to correct this finding: **POLICIES & PROCEDURES** The Plan identified its root cause being a delay in the delegate's notification templates. The Plan updated its procedure for communicating regulatory changes to the delegate.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
including translation of the clinical rationale, for threshold languages.	American Specialty Health reviewed the Plans HPUM updated Policies and supporting documents at the ASH Corporate Compliance Committee (CCC) on April 4, 2023. CCC had no initial concerns based on the documents reviewed at the CCC meeting. ASH will work cooperatively with the Plan to meet our responsibilities in accordance with the DHCS audit. Once the Plan has a final/approved policy it will be shared with ASH. ASH will review and develop a plan to implement the changes within 30 days.		April 4, 2023 Within 30 days of policy approval notification by Health Plan UM	• Plan Policy "SC.RUM.033 Delegation of UM Activities for DEs" was updated to reflect the changes to the Plan's UM process for communicating regulatory changes to the UM delegate to demonstrate how the delegate should be notified of changes & distribute updated NOA letter packets to members. (Section 5.5, page 4) **MONITORING & OVERSIGHT** • Audit Report "ASH Audit Tool" demonstrates the Plan's quarterly monitoring process by which the Plan conducts audits of the vendor's denial letters (NOA letters including all the attachments, NDN, LAT, appeal rights). The Plan began this process in June 2023 & will continue to conduct quarterly audits of its vendor. **The corrective action plan for finding 1.5.2 is accepted.**
1.5.3 SD - Nondiscrimination	Health Plan Utilization Management (HPUM) updated the NCAL UM Policy	1.5.3 SC.RUM.033 - Delegation of	April 24, 2023	The following documentation supports the Plan's efforts to correct this finding:

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Notice and Language Assistance Taglines: The Plan did not ensure a delegate sent updated NDN and LAT information to members with all written notices for UM decisions in accordance with APL 21-004.	28.0 – Delegation of UM Activities for Delegated Entities and SCAL UM Policy 33.0 – Delegation of UM Activities to reflect proper process and procedure for communicating regulatory changes to the notification templates. The policies will be reviewed and approved by the UM Committees on April 24, 2023. American Specialty Health reviewed the Plans HPUM updated Policies and supporting documents at the ASH Corporate Compliance Committee (CCC) on April 4, 2023. CCC had no initial concerns based on the documents reviewed at the CCC meeting. ASH will work cooperatively with the Plan to meet our responsibilities in accordance with the DHCS audit. Once the Plan has a final/approved policy it will be shared with ASH. ASH will review and develop	UM Activities for Delegated Entities	April 4, 2023 Within 30 days of policy approval notification by Health Plan UM	**POLICIES & PROCEDURES** The Plan identified its root cause being a delay in the delegate's notification templates. The Plan updated its procedure for communicating regulatory changes to the delegate. • Plan Policy "SC.RUM.033 Delegation of UM Activities for DEs" was updated to reflect the changes to the Plan's UM process for communicating regulatory changes to the UM delegate to demonstrate how the delegate should be notified of changes & distribute updated NDN & LAT information to members with all written notices for UM decisions. (Section 5.5, page 4) **MONITORING AND OVERSIGHT** • Audit Report "ASH Audit Tool" demonstrates the Plan's quarterly monitoring process which the Plan conducts audits of the vendor's NOA letter packets including attachments NDN, LAT & appeal rights. The Plan began this process in June 2023 & will continue to conduct quarterly audits of its vendor. **The corrective action plan for finding 1.5.3 is accepted.**

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	a plan to implement the changes within 30 days.			

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 - Use of Long-Term Services and Support (LTSS) Referral Questions: The Plan did not use LTSS referral questions to assess SPD members under 21 years of age when conducting HRA surveys.	The Plan trained staff to complete LTSS questions on SPD members of all ages, including members aged 0-21 on February 24, 2023. The Plan audited 10 random charts of members aged 0-21 with assessments completed between February 25, 2023 – April 6, 2023, for LTSS question completion on April 7, 2023. 100% of files were compliant. The Plan sent follow up educational email with audit results to staff on April 7, 2023.	2.1.1 LTSS-CCM Meeting agenda 2.1.1 LTSS-CCM Meeting Minutes 2.1.1 LTSS Questions for Pediatric members 2.1.1 Desktop Audits DHCS Audit Nov 2022	February 24, 2023 April 7, 2023 April 7, 2023	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • "Regional Care Coordination Case Management Team - Desktop Procedure" (04/07/23) which demonstrates that the MCP updated the desktop procedure to direct staff to include LTSS questions for all members of all ages, including those under age 21. (2023 DTP RCCCM, Page 18). **TRAINING** • Meeting Minutes, "Complex Case Management Teams Monthly Meeting" (02/24/23) which demonstrates that MCP staff were trained to complete LTSS questions on SPD members of all ages, including members aged 0-21. (LTSS -CCM Meeting_Minutes_02_24_23). **MONITORING AND OVERSIGHT** • Audit Results, "Random Charts LTSS Questions" (04/07/23) which demonstrates that the MCP audited 10 random charts of members aged 0-21 with assessments completed between February 25, 2023 – April 6, 2023, for LTSS question completion. 100% of files were

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				compliant. These audits are completed on a monthly basis. (Desktop_Audits_DHCS AUDIT NOV2022_LTSS.quest.040723). **The corrective action plan for finding 2.1.1 is accepted.**
2.5.1 - Implementation of Eating Disorder Coverage: The Plan did not implement all requirements for eating disorder coverage in accordance with APL 22-003.	The Plan validated it has been meeting most of the operational requirements of this APL since June 1, 2022. Following the audit, the Plan refined the following operational processes: 1. Coordination of Care: Plan members have been receiving care via San Diego (SD) County. Members receive care coordination, especially as the member nears discharge. The Plan receives notifications from Optum / San Diego County identifying the point of contact at the higher level of care program (ex: partial hospitalization, inpatient) so that the Plan and SD County can coordinate. The San Diego Behavioral Health Contacts in the	2.5.1 San Diego BH Contacts PPT 2.5.1 SD County email dated 10.21.2022 2.5.1 San Diego BH Contacts PPT 2.5.1 SD County email dated 10.21.2022 2.5.1 Final invoice Template San Diego County 2.5.1 SCHPHO.064 Eating Disorder	June 1, 2022 June 1, 2022 May 1, 2023 April 15, 2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policy SC.HPO.064 - Services to Med-Cal Members with Eating Disorders (4/15/23) has been finalized. Policy covers the requirements of APL-22-003. (2.5.1 - SC.HPHO.064_Services to Medi-Cal Members with Eating Disorders_Published 4.17.23) • Final invoice and SD County email confirm that the MCP and SD County have completed the division of financial responsibility agreement. (2.5.1 Final Invoice Template San Diego County & 2.5.1 SD County email dated 10.21.2022) **IMPLEMENTATION** Eating Disorder benefit communications occurred between KP/all San Diego MCPs and the County at regularly scheduled monthly Healthy San Diego (HSD) Behavioral Health Subcommittee and HSD BH Operations Work Team Meetings. MCP provided materials that were

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	PowerPoint demonstrates how this works. 2. Comprehensive case management is provided by the Plans San Diego Behavioral Health (KPBH). See page 2 of the San Diego Behavioral Health Contacts PowerPoint. 3. Delayed guidance from San Diego County resulted in delay of the division of financial responsibility. The Plan was dependent on San Diego County for this information. This process was completed in partnership with San Diego County in October 2022, after the audit. See (FW HSD BH Operations Subcommittee) final email, October 21, 2022. The email included the San Diego County Eating Disorder Policy and Procedure which is back dated to June 1, 2022. The final invoice template (Eating Disorder MCP Invoice Template 12.2) was received in December	Finalized Policy		shared between the MCP and SD County. The MCP's San Diego Department of Psychiatry Medi-Cal Liaison, participates in the workgroup; this involvement demonstrates that KPs providers and care delivery system is considered when MCP/County operational decisions are made. For MCP communications, information about how to implement the logical coordination logistics is done through staff and other meetings with the Eating Disorder Case Managers. Broader communication includes updates in the benefit resources such as Foundation Systems and training BH and other staff such as the Outside Referrals Department. (Benefit Communication- MCP Response 09-01-23 (Attachment B)) Materials and Topics from Meetings demonstrates how the Plan disseminates the information: • 6/3/22 Meeting – APL 22-003 requirements discussed; MOU discussed: ○ 7/7/22 - Meeting – County MHP Levels of Care ○ 8/29/22 Meeting – Eating disorder P&Ps, Eating disorder PowerPoint and Draft Eating Disorder MCP Reimbursement Invoice Template. ○ 9/15/22 Meeting – HSD MHP Plan Contact Card, MCP-MCP Shared Fiscal Responsibility PowerPoint

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	2022. We are currently working with San Diego County staff to update the One Link system which allows KP to pay the invoices that will be sent by San Diego County. To date, no invoices received even though members have been receiving services. 4. Finalized policy and procedure: Services to Medi-Cal Members with Eating Disorders policy.			○ 10/20/22 Meeting – Eating Disorder P&Ps, Eating Disorder Cost Schedule. ○ 12/2/22 Meeting - Contacting MCP at treatment request for notification and care coordination purposes, Eating Disorder MCP Invoice Process Onelink SD County Screen Shot document demonstrate that San Diego County has been added to OneLink and that the Plan can pay an invoice from San Diego for eating disorders. (2.5.1 OneLink SD County screen shot) Benefit Change Intake Document demonstrates the benefit system change showing severe mental illness as being covered in the Plan's benefit system as of January 1, 2023. (2.5.1 BCIF 244284 Medi-Cal Update to MHOPSVDX Benefit Service) BHSUD Medi-Cal APL Workflows demonstrate collaboration with counties and cost sharing for residential treatment and partial hospitalization. (2.5.1 - 3. BHSUD Medi-Cal APL Workflows) The MCP submitted a walkthrough of a Coordination of Care case walkthrough. The walkthrough described coordination between the

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				County Psychiatrist and the MCP's Liaison. (Coordination of Care and Walk-through- MCP Response 09-01-23 (Attachment B) The Plan provided a walkthrough for how KP staff have been trained on specific Behavioral Health Policies for eating disorders, No Wrong Door, and Screening and Transition of Care tools, and how policies have been implemented and monitored - from the lens of the member experience via call centers and care delivery. (Kaiser Member Services Virtual Walkthrough (10/12/23)). **The corrective action plan for finding 2.5.1 is accepted.**
2.5.2 - Implementation of No Wrong Door Mental Health Coverage: The Plan did not implement all new requirements for NSMHS coverage and coordination with the county MHP in accordance with APL 22-005.	In practice, the new benefits were implemented on time, but the Plan did not have the policy signed and approved by the Medi-Cal Policy Committee prior to the 2022 audit. The No Wrong Door policy was approved on April 17, 2023 (Refer to SCAL No Wrong Door Policy PD, section 5.1) The Plan covers: 1. NSMHS even without a definitive diagnosis. Because of our integrated delivery system, members are referred to KPBH for	2.5.2 SC.HPHO.062 No Wrong Door for Medi-Cal Members for MH Services Finalized Policy 2.5.2 SCPMG Reg Behavioral Health Training Overview	April 17, 2023 April 4, 2023 January 1, 2023	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • Approved policy, "SC.HPHO.62: No Wrong Door for Medi-Cal Members for Mental Health Services" (04/15/23) covers requirements for NSMHS coverage and coordination with the county MHP in accordance with APL 22-005. • "Reg BH Training Overview SD BH Contacts and Transition of Care Tool" demonstrates the MCP has implemented its coordination process with SD County. (2.5.2 SCPMG Reg Behavioral Health Training Overview (March, 2023))

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	assessment, and treatment starts even if not yet diagnosed. 2. NSMHS are provided even if there is not an individual treatment plan. 3. NSMHS are provided with or without SUD. 4. If member receives SMH services from the County and requires NSMHS, KP provides this through our integrated delivery system. The plan has implemented coordination processes with the County. Refer to SCPMG Regional Behavioral Health Training Overview PDF for process flow and training material that demonstrates that KP coordinates with SD County. The Transitions to and from County Power Point and San Diego BH Contacts Power Point provides specific contact information, further evidencing compliance. Benefits and claims systems were updated as of January 1, 2023. See	2.5.2 San Diego BH Contacts 2.5.2 Transitions to and from County 2.5.2 BCIF 244284 Medi-Cal Update to MHOPSVDS Benefit Services		• Benefit Change Intake Document demonstrates the benefit system change showing severe mental illness as being covered in the Plan's benefit system as of January 1, 2023. (2.5.2 BCIF 244284 Medi-Cal Update to MHOPSVDX Benefit Service (June submission)) **IMPLEMENTATION** • Benefit communications around Now Wrong Door / SMHS occurred between KP/all San Diego MCPs and the County at regularly scheduled monthly Healthy San Diego (HSD) Behavioral Health Subcommittee and HSD BH Operations Work Team Meetings. Beginning in November 2022, monthly and ad hoc BH Operations Work Team meetings focused on implementation of required screening and transition tools. (Benefit Communication- MCP Response 09-01-23 (Attachment B)) • 4/22/22 Meeting - HSD BH Operations Work Team reviewed APL 22-005 No Wrong Door • 12/15/22 Meeting - Screening Tool and Contact Screening Card shared. • 12/29/22 Screening Tools posted. • 1/5/23 Meeting - Most recent Screening Tool process maps, Transition Tool process maps, Current iteration of contact card

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	BCIF 24484Medi-Cal Update.pdf that demonstrates benefit and claim system update for all BH diagnosis.			• 1/19/23 Meeting - discuss the contacts for the Transition Tool • 2/17/23 - Screening Tool discussion • 4/6/23 - Screening and Transition Tool discussion. • No Wrong Door Coordination of Care Walk-through was provided by the MCP. The "HSD Screening Tool and Transition of Care Contact Card" serves as a resource for care coordination between the Managed Care Plans and the County and includes MCP contact information for Screening Form Transfers and Hours of Availability, Transition Tool Referral & Contact Card, Behavioral Health Liaison, Behavioral Health Department, and Health Plan Primary Liaison. • KP Screening Workflow: Initial member call to KP San Diego Psychiatry Call Center. KP completes the applicable Screening Tool. If the identified level of care is appropriate for KP, the member is booked for an appointment within required access timeframes. If the identified level of care is appropriate for referral to the County Mental Health Plan, KP contacts the Access & Crisis Line, sends the completed Screening Tool, and completes a warm transfer. If member requires NSMHS, KP provides those services. • KP Transition to the County for Specialty Mental Health Services: KP identifies that a member requires a higher level of care for specialty mental health services. (SMHS) KP contacts the ACL, County Mental

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				Health Clinic or contracted provider directly, sends the Transition of Care Tool, and completes a warm transfer. • County Screening Workflow: Initial member call to the County Access and Crisis Line (ACL). ACL completes the applicable Screening Tool. If the identified level of care is appropriate for MCP referral, ACL faxes the form to the KP Psychiatry Call Center and completes a warm transfer. • County Repatriation to KP for Non-Specialty Mental Health Services: The County identifies that a member no longer requires SMHS. The County Contacts the designated KP Psychiatry Medi-Cal Liaison and completes a warm transfer and sends the Transition of Care Tool. (Coordination of Care and Walk-through- MCP Response 09-01-23 (Attachment B) The Plan provided a walkthrough for how KP staff have been trained on specific Behavioral Health Policies for eating disorders, No Wrong Door, and Screening and Transition of Care tools, and how policies have been implemented and monitored - from the lens of the member experience via call centers and care delivery. (Kaiser Member Services Virtual Walkthrough (10/12/23)) **The corrective action plan for finding 2.5.2 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
2.5.3 - Implementation of Non-Specialty Mental Health Services: The Plan did not implement all requirements for coverage of NSMHS, including new benefits and covered populations, in accordance with APL 22-006.	• In practice, the new benefits were and are covered, the Plan just did not have the policy signed and approved by the Medi-Cal Policy Committee at time of the 2022 audit. The Plan also exceeds minimum requirements based on member need. The Non-Specialty Mental Health Services Policy and Procedure was approved on April 17, 2023 (Refer to SC.HPHO.063 Non-Specialty Mental Health Services PDF, section 5.2.3, 5.2.4) The Plan does provide: • NSMHS even without a definitive diagnosis. Members are referred to KPBH for assessment, and treatment starts even if not yet diagnosed. • Plan provides unlimited visits for individual and/or group counseling	2.5.3 SC.HPHO.063 Non-Specialty MH Services Finalized Published Policy	April 17, 2023	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • SC.HPHO.063 Non-Specialty Mental Health Services PDF updated to provide psychotherapy to Medi-Cal Members under the age of 21 with specified risk factors or with persistent mental health symptoms in the absence of a mental health disorder and cover up to 20 individual and/or group counseling sessions for pregnant and postpartum individuals with specified risk factors for perinatal depression when sessions are delivered during the prenatal period and/or during the 12 months following childbirth. (2.5.3 SC.HPHO.063_Non-Specialty Mental Health Services_Published 4.17.23) **IMPLEMENTATION** • County Level of Care Document share with BH clinicians to confirm understanding of which services are NSMH and SMH. (County MHP Levels of Care.6.2022.docx) • Benefit communications occurred between KP/all San Diego MCPs and the County at regularly scheduled monthly Healthy San

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	sessions for pregnant and postpartum individuals. The "Up to 20" is in the P&P, section 5.2.4. However, Plan can always provide more than the minimum if needed.			Diego (HSD) Behavioral Health Subcommittee and HSD BH Operations Work Team Meetings. (Benefit Communication- MCP Response 09-01-23 (Attachment B)) • MCP provided Coordination of Care & Case Walk-through. In March 2023, the KP Health Plan Primary Liaison received a voice mail message from a member who was recently released from the hospital and requested assistance with arranging for follow-up with Addiction Medicine. The KP Health Plan Primary Liaison contacted the KP Psychiatry Medi-Cal Liaison who informed the Psychiatry On-Duty Clinician of the need for care coordination. The member had both with mental health and SUD diagnosis. The Psychiatry clinician contacted the member and County Access & Crisis Line information for SUD services. Primary Care Physician and Psychiatry appointments were scheduled and completed within two days of the member's inquiry. During the psychiatry appointment, it was determined that the member required specialty mental health services and the KP Psychiatry Medi-Cal Liaison completed a warm transfer to a county provider. Should the member have required non-specialty mental health services, KP would have continued to provide behavioral health services. (Coordination of Care and Walk-through- MCP Response 09-01-23 (Attachment B))

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				The Plan provided a walkthrough for how KP staff have been trained on specific Behavioral Health Policies for eating disorders, No Wrong Door, and Screening and Transition of Care tools, and how policies have been implemented and monitored - from the lens of the member experience via call centers and care delivery. (Kaiser Member Services Virtual Walkthrough (10/12/23)) **The corrective action plan for finding 2.5.3 is accepted.**

3. Access and Availability of Care

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
3.6.1 - Family Planning Payment Reductions: The Plan inappropriately applied a fifty-percent payment reduction to service code 58300 (Insertion of birth control device).	The Plan identified a system issue that prevented surgical procedure codes (58300 - Insertion of birth control device) from being exempt from reimbursement cutback billed with modifier 51. The Plan is working on a long-term solution to pay mentioned codes at 100% of the Medi-Cal rate. The Plan anticipates the final system fix to be implemented by June 30, 2023. In the interim, Claim Operations created a process via a weekly monitoring report to identify and capture surgical procedure codes exempt from the reimbursement cutback billed with modifier 51 to ensure claims are paid according to DHCS guidelines. Process was implemented March 9, 2023, inclusive of staff education and remediation of impacted claims.	1. DHCS Audit 2022 Attachment 3.6.1 TPMG SAC MediCal Claims Examiner Meeting Agenda 03.09.23. 2. DHCS Audit 2022 Attachment B_3.6.1. Remediated Claims. 3. Weekly CLH80 Report 20230309_redacted.	June 30, 2023. March 9, 2023.	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • Screenshot**,** "Claim Example" to demonstrate that the MCP has implemented system changes to pay codes at 100% of the Medi-Cal rate. A hold code (CH380) is automatically applied by the system to prompt the claim examiner to confirm payment is 100% of the Medi-Cal Fee Schedule. This hold code is applied when a claim has 58300 billed with modifier 51. The system change went into effect on June 8, 2023. (Claim Example). • "Remediated Claims" (November 1 – March 2023) to demonstrate the MCP's remediation of impacted claims retroactive to the audit period. (DHCS Audit 2022 Attachment B_3.6.1. Remediated Claims). **TRAINING** • Meeting Agenda and Minutes, "SAC Claims Department Meeting" (03/09/23) to demonstrate that the MCP conducted training to staff to pay service code 58300 at the 100% Medi-Cal fee schedule rate. (TPMG SAC MediCal Claims Examiner Meeting Agenda 03.09.23).

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				MONITORING AND OVERSIGHT • "Weekly CLH80 Report" to demonstrate that the MCP created a weekly monitoring report to identify and capture surgical procedure codes exempt from the reimbursement cutback billed with modifier 51 to demonstrate claims are paid according to DHCS guidelines. (Weekly CLH80 Report). • Audit Report, "Monitoring Report Post Implementation 58300 with Modifier 51" to demonstrate that the MCP has implemented a monitoring process to demonstrate that code 58300 is paid at 100% of the Medi-Cal rate. The report includes the Date of Service, Code, Modifiers, and Total Billed. This report is monitored daily by the MCP's Claim Operations. (Monitoring Report Post Implementation). **The corrective action plan for finding 3.6.1 is accepted.**
3.6.2 SAC/SD - Family Planning Payments: The Plan did not distribute add-on payments for specified family	The Plan revised payment logic to distribute add-on payments for applicable family planning claims in accordance with APL 20-013 and APL 20-011.	3.6.2 SAC SD_Cancelled Checks Request_02-23-2023 with images.	October 14, 2022 November 1, 2022	The following documentation supports the Plan'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
planning claims in accordance with APL 20-013.	A system fix to prevent recurrence was implemented on October 14, 2022. Catch-up payments were issued to providers in November 2022.			• P&P, "POL-005: Payments to Providers" (06/27/22) states that claims adjudication complies with the rules of governing/regulatory bodies such as state and Federal law, and other requirements which may be applicable. • Updated, "SQL Table Screenshots" to demonstrate that the MCP updated their SQL database logic on October 14, 2022, to include the "At-Risk" population. Add-on payments are now distributed for all family planning claims (both At-Risk and Not At-Risk) in accordance with the APL 20-013 and APL 20-011. (SQL Table Screenshots, Sac_SD_Prop56 Changes). • "Checks Request with Images" in which catch-up payments were issued to providers in November 2022. (Checks Request with Images). **MONITORING AND OVERSIGHT** • "Prop 56 Audit Claims Internal" (Quarter 1, 2023) to demonstrate that the MCP has implemented a quarterly self-monitoring process to validate Prop 56 transactions which include Family Planning claims. The first self-monitoring process was done on March 29, 2023. (Self-Monitoring Results). **The corrective action plan for finding 3.6.2 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments

4. Member's Rights

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments

4.1.1 SAC - Nondiscrimination Notice (NDN) and Language Assistance Taglines (LAT): The Plan did not ensure that updated NDN and LAT information were posted in grievance acknowledgement and resolution letters in accordance with APL 21-004.	The Plan corrected the configuration issue to ensure updated NDN and LAT information is used. The issue was resolved as of January 24, 2023.	Updated NDN and LAT	January 24, 2023	The following documentation supports the Plan's efforts to correct this finding:
				
				The Plan resolved a back-end configuration issue that led to outdated nondiscrimination notices (NDNs) and language assistance taglines (LATs) and is fully aware of the requirements outlined in APL 21-004.
				
				POLICIES AND PROCEDURES
				
				• "Updated LAT_1557 Non-Standard NOLA"
				  ○ The Plan submitted an updated LAT document with recently added Ukrainian and Mein language translations (page 2, 3)
				  ○ "Updated 1557_NDN_English"
				  ○ The Plan submitted an updated NDN document with recently added contact information for DHCS' Office of Civil Rights and all protected discrimination characteristics (page 1, 2)
				
				The corrective action plan for finding 4.1.1 is accepted.

4.1.1 SD - Nondiscrimination Notice (NDN) and Language Assistance Taglines (LAT): The Plan did not ensure	The Plan corrected the configuration issue to ensure updated NDN and LAT information is used. The issue was resolved as of January 24, 2023.	Updated NDN and LAT	January 24, 2023	The following documentation supports the Plan's efforts to correct this finding: The Plan resolved a back-end configuration issue that led to outdated nondiscrimination notices (NDNs) and language assistance taglines (LATs) and is fully aware of the requirements outlined in APL 21-004.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
that updated NDN and LAT information were posted in grievance acknowledgement and resolution letters in accordance with APL 21-004.				**POLICIES AND PROCEDURES** • "Updated LAT_1557 Non-Standard NOLA" o The Plan submitted an updated LAT document with recently added Ukrainian and Mein language translations (page 2, 3) • "Updated 1557_NDN_English" o The Plan submitted an updated NDN document with recently added contact information for DHCS' Office of Civil Rights and all protected discrimination characteristics (page 1, 2) **The corrective action plan for finding 4.1.1 is accepted.**
4.1.2 SAC - Standard Grievance Resolution Timeframe: The Plan did not provide written resolution to members within 30 calendar days from the date of receipt of the grievance.	The Plan hired additional staff in 2022 to support the increased volume and continue to evaluate staffing resources to improve timeliness. The Plan is actively working to address these concerns and minimize the impact to our members. Specifically, we have a coordinated effort across our three entities (health plan, hospital, and medical group) to improve the member and patient experience and reduce overall		2022 and ongoing as needed April 19, 2023, and April 26, 2023	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policy, "Health Plan Compliance Monitoring Program" (12/16/22). This Compliance Monitoring Program is used to demonstrate oversight and monitoring to demonstrate KFHP, Inc. and KPIC compliance with the applicable regulatory and/or contract/agreement requirements.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	grievance volumes. Hiring efforts will continue this year to ensure we have staffing to meet member demand. Meetings held to review timeliness requirements with staff and make them aware of the finding.	Staff meeting presentation Staff meeting sign-in sheets		• Developing corrective actions for compliance recurrences to correct the underlying problem that results in program violations, prevent future misconduct, and demonstrate ongoing compliance with laws, regulations, and contract/agreement requirements. A CAP may be required if performance for a metric is non-complaint for three consecutive reporting periods or metric score occurrences. The CAP entry will include actions taken to date as outlined in the existing VRs for the three (3) non-compliant reporting periods as well as planned activity for effective remediation and will be entered as an action plan into the designated system of record for non-compliance. **MONITORING AND OVERSIGHT** • Written Statement by Plan, "When a grievance is created, METRS generates the regulatory activities that needs to be completed (i.e., acknowledgement, resolution), each with their own regulatory timeframe. Staff are able to reference these activities and their respective timeframes to demonstrate their assigned tasks are completed by the required timeframe. Additionally, these systematic tools enable operational managers to have daily oversight of grievances due and reinforce timeliness in real time." • Report, "KPI Dashboard Report", (05/01/23) demonstrates the Plan's ability to monitor grievance timeliness on a daily basis. This

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				screenshot is taken from Tableau, a self-service tool that tracks data in real time which allows operational leadership to oversee compliance with grievance and appeal timeframes on an ongoing basis. • A total of 780 were reviewed for timely resolution. 757 were timely and 27 were untimely. The compliancy rate was 97.05%. • Written Statement by Plan, "The Plan hired additional staff in 2022 to support the increased volume and continue to evaluate staffing sources to improve timeliness. The Plan is actively working to address these concerns and minimize the impact to our members. Specifically, we have a coordinated effort across our three entities (health plan, hospital, and medical group) to improve the member and patient experience and reduce overall grievance volumes. Hiring efforts will continue this year to demonstrate we have staffing to meet member demand." • Written Statement by Plan, "Delayed handoffs are primarily attributed to isolated human errors and are addressed with staff by management on a case-by-case basis to reinforce the process and requirements. The Plan would like to reinforce the primary driver of untimeliness has been increased volume."

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				• Written Statement by Plan, "Delayed investigations are primarily attributed to isolated human errors and are addressed with staff by management on a case-by-case basis to reinforce the process and requirements. The Plan would like to reinforce the primary driver of untimeliness has been increased volume." **TRAINING** • Training Materials, "2022 DHCS Findings & Requirement Overview" (04/19/23) demonstrates an overview of grievance timeliness requirements was presented to staff. **The corrective action plan for finding 4.1.2 (Sac) is accepted.**
4.1.2 SD - Standard Grievance Resolution Timeframe: The Plan did not provide written resolution to members within 30 calendar days from the date of receipt of the grievance.	The Plan hired additional staff in 2022 to support the increased volume and continue to evaluate staffing resources to improve timeliness. The Plan is actively working to address these concerns and minimize the impact to our members. Specifically, we have a coordinated effort across our three entities (health plan, hospital, and medical group) to improve the member and patient experience and reduce overall		2022 and ongoing as needed	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policy, "Health Plan Compliance Monitoring Program" (12/16/22). This Compliance Monitoring Program is used to demonstrate oversight and monitoring to demonstrate KFHP, Inc. and KPIC compliance with the applicable regulatory and/or contract/agreement requirements.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	grievance volumes. Hiring efforts will continue this year to ensure we have staffing to meet member demand. Meetings held to review timeliness requirements with staff and make them aware of the finding.	Staff meeting presentation Staff meeting sign-in sheets	April 19, 2023, and April 26, 2023	• Developing corrective actions for compliance recurrences to correct the underlying problem that results in program violations, prevent future misconduct, and demonstrate ongoing compliance with laws, regulations, and contract/agreement requirements. A CAP may be required if performance for a metric is non-complaint for three consecutive reporting periods or metric score occurrences. The CAP entry will include actions taken to date as outlined in the existing VRs for the three (3) non-compliant reporting periods as well as planned activity for effective remediation and will be entered as an action plan into the designated system of record for non-compliance. **MONITORING AND OVERSIGHT** • Written Statement by Plan, "When a grievance is created, METRS generates the regulatory activities that needs to be completed (i.e., acknowledgement, resolution), each with their own regulatory timeframe. Staff are able to reference these activities and their respective timeframes to demonstrate their assigned tasks are completed by the required timeframe. Additionally, these systematic tools enable operational managers to have daily oversight of grievances due and reinforce timeliness in real time." • Report, "KPI Dashboard Report", (05/01/23) demonstrates the Plan's ability to monitor grievance timeliness on a daily basis. This

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				screenshot is taken from Tableau, a self-service tool that tracks data in real time which allows operational leadership to oversee compliance with grievance and appeal timeframes on an ongoing basis. • A total of 780 were reviewed for timely resolution. 757 were timely and 27 were untimely. The compliancy rate was 97.05%. • Written Statement by Plan, "The Plan hired additional staff in 2022 to support the increased volume and continue to evaluate staffing sources to improve timeliness. The Plan is actively working to address these concerns and minimize the impact to our members. Specifically, we have a coordinated effort across our three entities (health plan, hospital, and medical group) to improve the member and patient experience and reduce overall grievance volumes. Hiring efforts will continue this year to demonstrate we have staffing to meet member demand." • Written Statement by Plan, "Delayed handoffs are primarily attributed to isolated human errors and are addressed with staff by management on a case-by-case basis to reinforce the process and requirements. The Plan would like to reinforce the primary driver of untimeliness has been increased volume."

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				• Written Statement by Plan, "Delayed investigations are primarily attributed to isolated human errors and are addressed with staff by management on a case-by-case basis to reinforce the process and requirements. The Plan would like to reinforce the primary driver of untimeliness has been increased volume." **TRAINING** • Training Materials, "2022 DHCS Findings & Requirement Overview" (04/19/23) demonstrates an overview of grievance timeliness requirements was presented to staff. **The corrective action plan for finding 4.1.2 (SD) is accepted.**
4.1.3 - Expedited Grievances Resolution: The Plan did not provide oral resolution to the member within the required 72-hour timeframe for expedited grievances.	The Plan hired additional staff in 2022 to support the increased volume and continue to evaluate staffing resources to improve timeliness. The Plan is actively working to address these concerns and minimize the impact to our members. Specifically, we have a coordinated effort across our three entities (health plan, hospital, and medical group) to improve the member and patient	Staff meeting presentation Staff meeting sign-in sheets	2022 and ongoing as needed April 19, 2023, and April 26, 2023	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policy, CA.MR.003, "California Non-Medicare Grievance and Appeals" (02/28/22) states, "for expedited grievances, a verbal and written resolution will be given to the member within the required 72-hour timeframe."

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	experience and reduce overall grievance volumes. Hiring efforts will continue this year to ensure we have staffing to meet member demand. Meetings were held to review timeliness requirements with staff and make them aware of the finding.			• Policy, "Health Plan Compliance Monitoring Program" (12/12/22). This Compliance Monitoring Program is used to demonstrate oversight and monitoring to demonstrate KFHP, Inc. and KPIC compliance with the applicable regulatory and/or contract/agreement requirements. • Developing corrective actions for compliance recurrences to correct the underlying problem that results in program violations, prevent future misconduct, and demonstrate ongoing compliance with laws, regulations, and contract/agreement requirements. A CAP may be required if performance for a metric is non-complaint for three consecutive reporting periods or metric score occurrences. The CAP entry will include actions taken to date as outlined in the existing VRs for the three (3) non-compliant reporting periods as well as planned activity for effective remediation and will be entered as an action plan into the designated system of record for non-compliance. **MONITORING AND OVERSIGHT** • Written Statement by Plan, "When a grievance is created, METRS generates the regulatory activities that needs to be completed (i.e., acknowledgement, resolution), each with their own regulatory timeframe. Staff are able to reference these activities and their respective timeframes to demonstrate their assigned tasks are

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				completed by the required timeframe. Additionally, these systematic tools enable operational managers to have daily oversight of grievances due and reinforce timeliness in real time." • Report, "KPI Dashboard Report", (05/01/23) demonstrates the Plan's ability to monitor grievance timeliness on a daily basis. This screenshot is taken from Tableau, a self-service tool that tracks data in real time which allows leadership to oversee compliance with grievance and appeal timeframes on an ongoing basis. • A total of 780 grievances were reviewed for timely resolution. 757 were timely and 27 were untimely. The compliancy rate was 97.05%. • Written Statement by Plan, "The Plan hired additional staff in 2022 to support the increased volume and continue to evaluate staffing sources to improve timeliness. The Plan is actively working to address these concerns and minimize the impact to our members. Specifically, we have a coordinated effort across our three entities (health plan, hospital, and medical group) to improve the member and patient experience and reduce overall grievance volumes. Hiring efforts will continue this year to demonstrate we have staffing to meet member demand." • Written Statement by Plan, "Delayed handoffs are primarily attributed to isolated human errors and are addressed with staff by

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				management on a case-by-case basis to reinforce the process and requirements. The Plan would like to reinforce the primary driver of untimeliness has been increased volume." • Written Statement by Plan, "Delayed investigations are primarily attributed to isolated human errors and are addressed with staff by management on a case-by-case basis to reinforce the process and requirements. The Plan would like to reinforce the primary driver of untimeliness has been increased volume." **TRAINING** • Training Materials, "2022 DHCS Findings & Requirement Overview" and Attestations (04/19/23) demonstrates an overview of grievance timeliness requirements was presented to staff. **The corrective action plan for finding 4.1.3 is accepted.**
4.1.4 - Written Notification of ievance esolution Delays: e Plan did not otify members of esolution delays in writing for grievances	The Plan has corrected the system issue to ensure grievance delay notifications are sent as required. The issue was resolved as of March 23, 2023.		March 23, 2023	The following supporting documentation supports the Plan's efforts to resolve this finding: **POLICIES AND PROCEDURES** • Plan Policy CA.MR.003 California Non-Medicare Grievance and Appeals (revised 02/28/2022) stated if a resolution cannot be

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
not resolved within 30 calendar days.				provided within 30 days, the member must be notified in writing within the 30-day resolution time frame for grievances. **MONITORING AND OVERSIGHT** • Resolution delay notices are sent to members automatically by the Plan's tracking system when the resolutions could not be reached within 30 calendar days. Due to a system error, resolution delay notices were not sent automatically when cases were submitted by someone other than the member where written member authorization was pending. • Plan has corrected the system issue to demonstrate grievance delay notifications are sent as required. This issue was resolved as of March 23, 2023. • In March 2020, the Plan began sending this notice automatically for untimely grievances which, for the most part, has successfully demonstrate members are notified of the Plan's delay as contractually required. Staff are able to reference this activity as a part of their assigned grievance to demonstrate it was completed by the required timeframe. • Plan submitted a screenshot of Delay Letter Analysis as evidence of the Plan's ability to monitor grievance timeliness. The screenshot is

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				taken from Tableau, a self-service tool that tracks data in real time which allows leadership to oversee compliance with grievance and appeal timeframes on an ongoing basis. **The corrective action plan for finding 4.1.4 is accepted.**
4.1.5 SAC - Investigation and Resolution of Discrimination Complaints: The Plan did not ensure that grievances with alleged discrimination were investigated by the discrimination grievance coordinator and resolved within the grievance system.	Meetings have been held to remind staff that all discrimination issues must be identified, investigated with the appropriate designated Discrimination Coordinator who will provide response for resolution within the grievance system. Additionally, the Plan is in the process of developing a system reminder for staff, expected to deploy May 16, 2023, to ensure discrimination grievances are appropriately identified, investigated, and resolved within the grievance system.	Staff meeting presentation Staff meeting sign-in sheets	April 19, 2023, and April 26, 2023 May 16, 2023	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policy CA.MR.003 California Non-Medicaid Grievance and Appeals has been revised to include the following: Civil Rights Complaints. Plan must demonstrate all grievance alleging discrimination are investigated by and resolved with the involvement of designated discrimination grievance coordinators. (Section 5.51) **TRAINING** • Handling and Reporting of Discrimination Grievances Training provided staff an overview of the requirements, audit findings and DHCS comments. Plan procedures require all alleged discrimination complaints be coded in METRS. METRS will assist staff in identifying potential discrimination issues and remind staff to code alleged

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments

				discrimination issues once validated. Alleged discrimination cases are then forwarded to Civil Rights Coordinators for investigation and resolution.
				
				• Training topics included the following:
				  ○ Investigation and reporting of discrimination grievances.
				  ○ Notification to DHCS requirements.
				  ○ Timeliness of discrimination complaints reporting.
				
				MONITORING AND OVERSIGHT
				
				• Plan established a system reminder, a pop up that indicates a potential discrimination has been identified based on case synopsis. The pop up reminds staff to identify and investigate all allegations of discrimination. If an allegation of discrimination is found, it must be coded and follow the appropriate investigative process.
				
				• The Plan tracks through Plan internal monitoring program (quarterly) and includes retrospective review of grievances to support quality assurance and improvement. Additionally, the quarterly audit tool has been updated to include specific references to discrimination grievance criteria.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				The corrective action plan for finding 4.1.5 is accepted.
4.1.5 SD - Investigation and Resolution of Discrimination Complaints: The Plan did not ensure that grievances with alleged discrimination were investigated by the discrimination grievance coordinator and resolved within the grievance system.	Meetings have been held to remind staff that all discrimination issues must be identified, investigated with the appropriate designated Discrimination Coordinator who will provide response for resolution within the grievance system. Additionally, the Plan is in the process of developing a system reminder for staff, expected to deploy May 16, 2023, to ensure discrimination grievances are appropriately identified, investigated, and resolved within the grievance system.	Staff meeting presentation Staff meeting sign-in sheets	April 19, 2023, and April 26, 2023 May 16, 2023	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policy CA.MR.003 California Non-Medicaid Grievance and Appeals has been revised to include the following: Civil Rights Complaints. Plan must demonstrate all grievance alleging discrimination are investigated by and resolved with the involvement of designated discrimination grievance coordinators. (Section 5.51) **TRAINING** • Handling and Reporting of Discrimination Grievances • Training provided staff an overview of the requirements, audit findings and DHCS comments. Plan procedures require all alleged discrimination complaints be coded in METRS. METRS will assist staff in identifying potential discrimination issues and remind staff to code alleged discrimination issues once validated. Alleged discrimination cases are then forwarded to Civil Rights Coordinators for investigation and resolution.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments

				• Training topics included the following:
				  ○ Investigation and reporting of discrimination grievances.
				  ○ Notification to DHCS requirements.
				  ○ Timeliness of discrimination complaints reporting.
				
				MONITORING AND OVERSIGHT
				
				• Plan established a system reminder, a pop up that indicates a potential discrimination has been identified based on case synopsis. The pop up reminds staff to identify and investigate all allegations of discrimination. If an allegation of discrimination is found, it must be coded and follow the appropriate investigative process.
				
				• The Plan tracks through Plan internal monitoring program (quarterly) and includes retrospective review of grievances to support quality assurance and improvement. Additionally, the quarterly audit tool has been updated to include specific references to discrimination grievance criteria.
				
				The corrective action plan for finding 4.1.5 is accepted.

4.1.6 SAC - Timeliness of Discrimination	The Plan has corrected the system/data configuration error to ensure cases containing discrimination	Staff meeting presentation	July 12, 2023	The following documentation supports the Plan's efforts to correct this finding:

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
Complaints Reporting: The Plan did not forward all grievances with alleged discrimination to DHCS within ten calendar days of the grievance resolution.	issues can be identified for reporting as required. The issue was resolved as of July 12, 2022. Additionally, the Plan is in the process of developing a system reminder for staff, expected to deploy May 16, 2023, to ensure discrimination grievances are appropriately identified and captured for reporting. Finally, meetings were held to remind staff that all discrimination issues must be systematically identified to ensure timely reporting.	Staff meeting sign-in sheets	May 16, 2023 April 19, 2023, and April 26, 2023	**POLICIES AND PROCEDURES** • Policy CA.MR.003 California Non-Medicaid Grievance and Appeals Section 5.5.1 has been revised to include the following: Civil Rights Complaints. Plan must demonstrate all grievance alleging discrimination are investigated by and resolved with the involvement of designated discrimination grievance coordinators. • Outlines requirement to submit discrimination related grievances to DHCS Office of Civil Rights within 10 days of mailing a discrimination grievance letter. **TRAINING** Handling and Reporting of Discrimination Grievances. Training provided staff an overview of the requirements, audit findings and DHCS comments. • Plan procedures require all alleged discrimination complaints be coded in METRS. METRS will assist staff in identifying potential discrimination issues and remind staff to code alleged discrimination issues once validated. Alleged discrimination cases are then forwarded to Civil Rights Coordinators for investigation and resolution.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				• Training topics included the following: Investigation and reporting of discrimination grievances. Notification to DHCS requirements. Timeliness of discrimination complaints reporting. **MONITORING AND OVERSIGHT** • System Reminder – Pop up reminder to identify and investigate all allegations of discrimination based on case synopsis. If an allegation of discrimination is found, it must be coded and follow the appropriate investigative process. • The Plan tracks through Plan internal monitoring program (quarterly) and includes retrospective review of grievances to support quality assurance and improvement. Additionally, the quarterly audit tool has been updated to include specific references to discrimination grievance criteria. • Discrimination Grievances SOP – Ethics and Compliance Office Outlines guidance and procedures used to investigate and report issues of discrimination to DHCS within the required 10-day timeframe. SOP includes a workflow.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				• Monitoring activity includes weekly review of open/closed cases. Case coordinator will validate reporting requirements and follow up with discrimination grievance coordinators to demonstrate case file is complete prior to submission to DHCS within 10 days of member notification. Process to be implemented 9/1/23. **This corrective action plan for finding 4.1.6 is accepted.**
4.1.6 SD - Timeliness of Discrimination Complaints Reporting: The Plan did not ensure that all grievances with alleged discrimination were forwarded to DHCS within ten calendar days of the grievance resolution.	The Plan corrected the system/data configuration error to ensure cases containing discrimination issues can be identified for reporting as required. The issue was resolved as of July 12, 2022. Additionally, the Plan is in the process of developing a system reminder for staff, expected to deploy May 16, 2023, to ensure discrimination grievances are appropriately identified and captured for reporting. Finally, meetings were held to remind staff that all discrimination issues	Staff meeting presentation Staff meeting sign-in sheets	July 12, 2023 May 16, 2023 April 19, 2023, and April 26, 2023	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policy CA.MR.003 California Non-Medicaid Grievance and Appeals Section 5.5.1 has been revised to include the following: Civil Rights Complaints. Plan must demonstrate all grievance alleging discrimination are investigated by and resolved with the involvement of designated discrimination grievance coordinators. • Outlines requirement to submit discrimination related grievances to DHCS Office of Civil Rights within 10 days of mailing a discrimination grievance letter. **TRAINING**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	must be systematically identified to ensure timely reporting.			Handling and Reporting of Discrimination Grievances • Training provided staff an overview of the requirements, audit findings and DHCS comments. • Plan procedures require all alleged discrimination complaints be coded in METRS. METRS will assist staff in identifying potential discrimination issues and remind staff to code alleged discrimination issues once validated. Alleged discrimination cases are then forwarded to Civil Rights Coordinators for investigation and resolution. • Training topics included the following: o Investigation and reporting of discrimination grievances. o Notification to DHCS requirements. o Timeliness of discrimination complaints reporting. **MONITORING AND OVERSIGHT** • System Reminder – o Pop up reminder to identify and investigate all allegations of discrimination based on case synopsis. If an allegation of discrimination is found, it must be coded and follow the appropriate investigative process.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				• The Plan tracks through Plan internal monitoring program (quarterly) and includes retrospective review of grievances to support quality assurance and improvement. Additionally, the quarterly audit tool has been updated to include specific references to discrimination grievance criteria. • Discrimination Grievances SOP – Ethics and Compliance Office Outlines guidance and procedures used to investigate and report issues of discrimination to DHCS within the required 10-day timeframe. SOP includes a workflow. • Monitoring activity includes weekly review of open/closed cases. Case coordinator will validate reporting requirements and follow up with discrimination grievance coordinators to demonstrate case file is complete prior to submission to DHCS within 10 days of member notification. Process to be implemented 9/1/23. **This corrective action plan for finding 4.1.6 is accepted.**
4.1.7 SAC - Discrimination Grievances Email to DHCS Office for Civil Rights (OCR): The Plan's emails to DHCS	The Plan is establishing a streamlined process for ensuring all details contained in the grievance and beyond, as a part of the investigation/corrective action, are effectively provided via email to the		September 30, 2023	The following documentation supports the Plan'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
regarding grievances with alleged discrimination did not have all required information as specified in APL 21-004.	DHCS within ten calendar days from grievance resolution.			• The Plan developed and implemented policies and procedures to demonstrate that the Plan's emails to DHCS regarding grievances with alleged discrimination now include all required information in accordance with APL 21-004. • The Plan developed Standard Operating Procedure for CA Discrimination Grievance Investigations, Ethics and Compliance Office, which outlines guidance and procedures for discrimination grievance coordinators to investigate and report issues of discrimination to DHCS within the required 10-day timeframe. ("4.1.6_4.1.7_Discrimination Grievance SOP") **OVERSIGHT AND MONITORING** • Monitoring activity includes weekly review of open/closed cases. Case coordinator will validate reporting requirements and follow up with discrimination grievance coordinators to demonstrate case file is complete prior to submission to DHCS within 10 days of member notification. Process implemented on 9/1/23. A concise workflow for staff is included in the SOP (page 2, SOP). **The corrective action plan for finding 4.1.7 SAC is accepted.**
4.1.7 SD - Discrimination Grievances Email to	The Plan is establishing a streamlined process for ensuring all details contained in the grievance and		September 30, 2023	The following documentation supports the Plan's efforts to correct this finding:

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
DHCS Office for Civil Rights (OCR): The Plan's emails to DHCS regarding grievances with alleged discrimination did not have all required information as specified in APL 21-004.	beyond, as a part of the investigation/corrective action, are effectively provided via email to the DHCS within ten calendar days from grievance resolution.			**POLICIES AND PROCEDURES** • The Plan developed and implemented policies and procedures to demonstrate that the Plan's emails to DHCS regarding grievances with alleged discrimination now include all required information in accordance with APL 21-004. • The Plan developed Standard Operating Procedure for CA Discrimination Grievance Investigations, Ethics and Compliance Office, which outlines guidance and procedures for discrimination grievance coordinators to investigate and report issues of discrimination to DHCS within the required 10-day timeframe. ("4.1.6_4.1.7_Discrimination Grievance SOP") **OVERSIGHT AND MONITORING** • Monitoring activity includes weekly review of open/closed cases. Case coordinator will validate reporting requirements and follow up with discrimination grievance coordinators to demonstrate case file is complete prior to submission to DHCS within 10 days of member notification. Process implemented on 9/1/23. A concise workflow for staff is included in the SOP (page 2, SOP). **The corrective action plan for finding 4.1.7 SD is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
4.1.8 SAC - Resolution of Complaints in Grievances: The Plan sent resolution letters for grievances without completely resolving all member complaints.	Effective January 1, 2023, the Plan established a centralized team dedicated to processing grievances for Medi-Cal enrollees. This team is comprised of subject matter experts with the ability and expertise to adhere to grievance processes and requirements specific to the Medi-Cal population, which enables the Plan to investigate member complaints more thoroughly prior to sending resolution. Additionally, meetings were held to remind staff that all issues must be investigated and resolved.	Staff meeting presentation Staff meeting sign-in sheets	January 1, 2023 April 19, 2023, and April 26, 2023	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policy, "California Non-Medicare Grievance and Appeals" (02/28/22). The Grievance, Initial Determinations, and Appeal data will be routinely monitored and analyzed for trends as a component of the KFHP quality assurance/improvement program. Review will result in recommended action plans that will be implemented and monitored for improvement. In accordance with specified schedules, grievance and appeal data will also be supplied to regulators. • In addition, The Plan's internal percentage rate goal is 95% compliance for Medi-Cal. The Plan's 95% rate is an operational benchmark based on historic performance; when not achieved, highlights the potential for systemic issues resulting in non-compliance. In such instances, formal root cause analysis is performed to identify trends and establish structured remediation efforts. **MONITORING AND OVERSIGHT**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				• Sample Scorecard, "Master Medicaid Scorecard" demonstrates an internal audit and monitoring will take place on a quarterly basis and includes a retrospective review of Medi-Cal grievances against regulatory requirements. The results are reviewed to identify areas needing improvement to support quality assurance and improvement. If underperformance is identified two consecutive quarters, a root cause analyses will be performed, and remediation efforts will be initiated. Underperformance for three consecutive quarters will result in an internal CAP that will remain open until the performance target is met. • Written Statement by Plan, "Effective January 1, 2023, the Plan established a centralized team dedicated to processing grievances for Medi-Cal enrollees. This team is comprised of subject matter experts with the ability and expertise to adhere to grievance processes and requirements specific to the Medi-Cal population, which enables the Plan to investigate member complaints more thoroughly prior to sending resolution." **TRAINING** • Training Materials, "2022 DHCS Findings & Requirement Overview" and Attestations (04/19/23) demonstrates the Plan gave an overview

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				to staff of grievance timeliness requirements and that all issues must be investigated and resolved. **The corrective action plan for finding 4.1.8 SAC is accepted.**
4.1.8 SD - Resolution of Complaints in Grievances: The Plan sent resolution letters for grievances without completely resolving all member complaints.	Effective January 1, 2023, the Plan established a centralized team dedicated to processing grievances for Medi-Cal enrollees. This team is comprised of subject matter experts with the ability and expertise to adhere to grievance processes and requirements specific to the Medi-Cal population, which enables the Plan to investigate member complaints more thoroughly prior to sending resolution. Additionally, meetings were held to remind staff that all issues must be investigated and resolved.	Staff meeting presentation Staff meeting sign-in sheets	January 1, 2023 April 19, 2023, and April 26, 2023	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policy, "California Non-Medicare Grievance and Appeals" (02/28/22). The Grievance, Initial Determinations, and Appeal data will be routinely monitored and analyzed for trends as a component of the KFHP quality assurance/improvement program. Review will result in recommended action plans that will be implemented and monitored for improvement. In accordance with specified schedules, grievance and appeal data will also be supplied to regulators. • In addition, The Plan's internal percentage rate goal is 95% compliance for Medi-Cal. The Plan's 95% rate is an operational benchmark based on historic performance; when not achieved, highlights the potential for systemic issues resulting in non-compliance. In such instances, formal root cause analysis is performed to identify trends and establish structured remediation efforts.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				MONITORING AND OVERSIGHT • Sample Scorecard, "Master Medicaid Scorecard" demonstrates an internal audit and monitoring will take place on a quarterly basis and includes a retrospective review of Medi-Cal grievances against regulatory requirements. The results are reviewed to identify areas needing improvement to support quality assurance and improvement. • If underperformance is identified two consecutive quarters, a root cause analyses will be performed, and remediation efforts will be initiated. Underperformance for three consecutive quarters will result in an internal CAP that will remain open until the performance target is met. • Written Statement by Plan, "Effective January 1, 2023, the Plan established a centralized team dedicated to processing grievances for Medi-Cal enrollees. This team is comprised of subject matter experts with the ability and expertise to adhere to grievance processes and requirements specific to the Medi-Cal population, which enables the Plan to investigate member complaints more thoroughly prior to sending resolution." **TRAINING**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				• Training Materials, "2022 DHCS Findings & Requirement Overview" and Attestations (04/19/23) demonstrates the Plan gave an overview to staff of grievance timeliness requirements and that all issues must be investigated and resolved. **The corrective action plan for finding 4.1.8 SD is accepted.**
4.1.9 - Clear and Concise Grievance Resolution Letter: The Plan did not ensure grievance resolution letters contained a clear and concise explanation of the Plan's decision.	The Plan will implement an increased clinical engagement effort, in which clinicians will be more readily accessible, as needed, for consult and review of resolution letters to support staff in communicating clinical information, such as simplifying medical terminology and criteria references, to ensure resolutions are clear and concise. Additionally, meetings were held to remind staff that the outcome(s) of the Plan's review must be communicated clearly and concisely in the resolution letter.	Staff meeting presentation Staff meeting sign-in sheets	May 1, 2023 April 19, 2023 and April 26, 2023	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policy, "California Non-Medicare Grievance and Appeals" (02/28/22) o The Grievance, Initial Determinations, and Appeal data will be routinely monitored and analyzed for trends as a component of the KFHP quality assurance/improvement program. Review will result in recommended action plans that will be implemented and monitored for improvement. In accordance with specified schedules, grievance and appeal data will also be supplied to regulators. (Section 5.1.7.) o "All written information provided to members will be written in accordance with timelines, notice content, and format requirements outlined in State requirements and 42 CFR 438.10, 406 and 408. In accordance with the KFHP contract with the

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				DHCS, all written information provided to members will be at a sixth grade reading level." (Section 5.18.) **MONITORING AND OVERSIGHT** • Sample Scorecard, "Master Medicaid Scorecard" Demonstrates an internal audit and monitoring will take place on a quarterly basis and includes a retrospective review of Medi-Cal grievances against regulatory requirements. The results are reviewed to identify areas needing improvement to support quality assurance and improvement. • If underperformance is identified two consecutive quarters, a root cause analyses will be performed, and remediation efforts will be initiated. Underperformance for three consecutive quarters will result in an internal CAP that will remain open until the performance target is met. • Written Statement by Plan, "The Plan will implement an increased clinical engagement effort, in which clinicians will be more readily accessible, as needed, for consult and review of resolution letters to support staff in communicating clinical information, such as simplifying medical terminology and criteria references, to demonstrate resolutions are clear and concise."

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				TRAINING • Training, "2022 DHCS Findings & Requirement Overview" and Attestations (04/19/23) demonstrates the Plan gave an overview to remind staff that the outcome(s) of the Plan's review must be communicated clearly and concisely in the resolution letter. **The corrective action plan for finding 4.1.9 is accepted.**
4.1.10 - Public Policy Body's Review of Grievances: The Plan's public policy body did not periodically review written grievance logs or reports and did not thoroughly document the review.	The Plan will incorporate grievance reporting for the period January 2022 through March 2023 in the May 2023 GMC San Diego Public Policy Committee Meeting. In Q4 2023, the committee will receive grievance reporting for the period Q2 and Q3 2023. Grievance reporting will be documented in the Public Policy Committee Minutes and the minutes will report up to the Southern California Quality Oversight Committee (SQOC). The Plan will develop and implement MAC procedures to ensure going forward that the Public Policy		May 2023 May 2023	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • Plan document "San Diego GMC Member Advisory Committee (MAC) Charter (updated 12/19/19)" stated that the MAC, the Plan's public policy body, is a formal mechanism to involve Medi-Cal members as partners in identifying improvement opportunities for the Southern California region. Membership includes San Diego GMC Medi-Cal members, Plan physicians, and Plan leadership and staff. The MAC meets quarterly and develops objectives based on Medi-Cal regulatory changes, performance improvement needs, Medi-Cal member needs, and operational needs. (Medical Audit Report, page 65) • Member Advisory Committee 2023 Charter

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	Committee periodically reviews written grievance reports annually and documents its review accordingly in the minutes.			○ The charter demonstrates the MAC's annual priorities & goals including an annual review of grievance & appeals reporting, volumes, & areas that need improvement. [Page 2] **MONITORING AND OVERSIGHT** • Member Advisory Committee 2023 Charter ○ The charter demonstrates the MAC's annual priorities & goals including an annual review of grievance & appeals reporting, volumes, & areas that need improvement. [Page 2] • Q2 MAC 2023 Meeting Minutes ○ The meeting minutes demonstrates documentation of the review of the Medi-Cal Grievance Report by the Plan's Member Advisory Committee (MAC). • SCAL Medi-Cal (GMC San Diego) Grievance Report ○ The report demonstrates that the Plan reviewed grievance & appeals data with the MAC at the June – Q2 meeting. *This procedure was part of the Plan's CAP to begin implementing after this finding was identified.* **The corrective action plan for finding 4.1.10 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
4.2.1 - Written Program Description: The Plan's CLS Program organizational chart did not have all required elements.	The Plan updated its Cultural and Linguistic Services (CLS) Program Description to include the CLS Program Organizational Chart. The CLS Written Program Description includes the following required elements: • It should show the key staff persons with overall responsibility for the program; (Page 3) • It should include a narrative that explains the chart and describes the oversight and direction to the Community Advisory Committee, provisions for supporting staff and reporting relationships (Page 3 and Page 10) It should also show the qualifications of staff, including appropriate education, experience, and training (Pages 3, 4, 5).	4.2.1 Written Program Description	January 2023	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • Written Program Description o The CLS Written Program Description was updated & includes the required elements: ▪ Shows key staff persons with overall responsibility of the program; (Page 3) ▪ Includes a narrative that explains the chart & describes the oversight; (Page 3 & 10) ▪ Shows the staff's qualifications, including appropriate education, experience & training. (Pages 3, 4, & 5) **MONITORING AND OVERSIGHT** • Written Program Description o The CLS Program Description & Org Chart are reviewed & if needed, updated, annually to verify that the Plan's CLS Program organizational chart continues to have all the required elements.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				The corrective action plan for finding 4.2.1 is accepted.
4.2.2 SD - Nondiscrimination Notice (NDN) and Language Assistance Taglines (LAT): The Plan did not ensure that correct NDN and LAT information were posted in all Medi-Cal vital documents in accordance with APL 21-004.	**<u>Partners in Health Newsletter:</u>** The Plan updated the Partners in Health (PIH) Newsletter in accordance with APL 21-004 (Standards for Determining Threshold Languages Nondiscrimination requirements and Language Assistance Services). The update is applicable to both Sacramento and San Diego GMC. Attached as evidence of the update is the March 2023 Partners in Health Newsletter which contains the full-sized language assistance taglines (LAT), the nondiscrimination notice (NDN), and the contact information for members to file a discrimination grievance with the DHCS Office of Civil Rights (OCR). The last page of the newsletter contains a link to "Other Languages", select the region (California Northern	4.2.2 Sac/SD NDN_LAT PIH Newsletter March 2023 (active links also included) 4.2.2 Sac-SD Nondiscrimination notice and LAT Services to see the update of Mien and Ukrainian languages. Link also listed under "action taken" 4.2.2 Sac/San Diego Policy: Quality Translation Policy for Member	March 2023 January 2023 November 1, 2022 March 2023	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • The Plan implemented policies and procedures to demonstrate updated nondiscrimination notices (NDNs) and language assistance taglines (LATs) are included in all member-informational notices, in accordance with the requirements outlined in APL 21-004. • The Plan updated translation policy, "4.2.2 Sac/San Diego Policy: Quality Translation Policy for Member Informing Materials", to define and support the requirements for inclusion of the NDN and LAT in the member informational notices. (See section 8.2.1 and section 9.2 & 9.2.1). In addition, Section 5.2 delineates Medi-Cal informing materials to include the provider directory, website, and newsletters. • The Plan updated their website with full-sized NDN and LAT templates "4.2.2 Sac and San Diego_Nondiscrimination Notice and Language Assistance Services", which now provides contact information for members to file a discrimination grievance with DHCS' Office of Civil Rights. The updated LAT notice also includes missing Mien and Ukrainian languages.

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	or Southern) to view the LAT, including languages Mien and Ukrainian. Select the non-discrimination notice link to view the full-sized NDN and the OCR update. **KP.Org:** The Plan's website has been updated with the updated full-sized NDN and LAT templates. The updated NDN notice has the DHCS OCR contact information and all protected discrimination categories, such as ethnic group identification and medical condition. The updated LAT notice includes Mien and Ukrainian languages. NDN LAT The Plan has implemented the Translation policy and procedures to define and support the requirements	Informing Materials 4.2.2 SD NDN and LAT Provider Directory March 2023		○ "Sac/SD NDN_LAT PIH Newsletter March 2023". The Plan updated the Partners in Health (PIH) Newsletter in accordance with APL 21-004. The Plan provided links of these notices on their website; DHCS verified the links and that missing languages (Mien and Ukrainian) are now included. (4.2.2 Sac_San Diego NDN_LAT_PIHNewsletterMarch2023 (3) **OVERSIGHT AND MONITORING** • A sample Distribution List tracker, "Draft LAT_NDN Stakeholder Distribution List for MCAL LOB", demonstrates the Plan's oversight process and its functional area contacts to be placed on a reminder email distribution list. Plan provided a "Statement for DHCS CAP 4.2.2_v2" in which Plan outlines their process for validating NDN and LAT contacts in the GMC San Diego and GMC Sacramento regions. The Plan provided a copy of the departmental reminder email that will be used for the distribution list ("Draft Reminder Email"). • In addition, the Plan has set long-term milestones to include a finalized list of functional area contacts will be placed on an email distribution list (by 10/31/23); reminders will also be sent out to all relevant contacts to use the most updated LATs & NDNs for member informing materials (by 11/15/23); and will provide to DHCS annual attestations from all functional area departments to confirm

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	for inclusion of the NDN and LAT in the member informational notices. (Refer to attached policy section 8.2.1 and section 9.2 & 9.2.1). **Provider Directory:** In accordance with the requirements of APL 21-004, the Plan implemented policy Quality Translation Process for Member Informing Materials. Section 5.2 delineates Medi-Cal informing materials to include the provider directory, website, and newsletters. Effective March 2023, the newsletter, website, and provider directory are remediated to include the correct NDN and LAT and OCR contact information.			that all functional areas are using the correct versions of NDN & LATs (by 12/31/23). **The corrective action plan for finding 4.2.2 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 SAC/SD - Educational Interventions: The Plan did not provide educational interventions to address two topics within the Effective Use of Managed Health Care Services category: Managed Health Care and Health Education Services.	The Plan is submitting educational interventions to address two topics within the Effective Use of MHCS category: Managed Health Care and Health Education Services. The two topic areas were on KP.org during the 2022 audit review period (November 1, 2021 – October 31, 2022). The Plan missed submitting these documents to DHCS during the pre and post audit phase. The Plan will ensure these documents are submitted timely in future audits to evidence compliance.	6.1.1 Sac-SD Health Education Service Topic 6.1.1 Sac-SD Managed Health Care Topic		The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated, "Health Education Policy" (07/28/23) to demonstrate that the MCP addresses educational interventions and topics. The MCP will maintain a Health Education system that provides educational interventions addressing health categories and topics including education regarding the appropriate use of health care services, risk-reduction and healthy lifestyles, and self-care and management of health conditions. (Medi-Cal Requirements for Health Education). • Website Samples, "Managed Health Care Topic" (April 2023) from the MCP's website which demonstrates that the MCP has educational interventions for the topic of Managed Health Care. The website samples included how to get care, information about Medi-Cal, and finding doctors and locations. (SAC_SD Managed Health Care Topic). • Website Samples, "Education Service Topic" (April 2023) from the MCP's website which demonstrates that the MCP has educational interventions for the topic of Health Education Services. The website

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				samples included information on health and wellness, health programs and classes, and healthy lifestyle programs. (SAC_SD Health Education Service Topic). **The corrective action plan for finding 6.1.1 is accepted.**
6.2.1 SAC/SD - Prompt Referral of Any Potential Fraud or Abuse: The Plan did not report suspected fraud and/or abuse to DHCS within ten working days of the date it first became aware.	Effective May 1, 2023, the National Special Investigations Unit (NSIU) will determine Medi-Cal line of business impact prior to completing analysis to ensure timely notification to DHCS.	1) Regulatory Referral Instructions for Medi-Cal NCAL 2) Regulatory Referral Instructions for Medi-Cal SCAL 3) Template Response Verbiage DHCS Initial Notification MC609 4) Template Response Verbiage Unsubstantiated DHCS Final	May 1, 2023	The following documentation supports the Plan's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated P&P, "NATL.EC.011: Fraud, Waste, and Abuse Control" (07/01/23) to demonstrate that the MCP will submit fraud and/or waste referrals to DHCS within the required timeframe of ten working days. (Fraud Waste and Abuse Control Policy, FWA EC.11 Policy Appendix A). **TRAINING** • "Investigations Team Meeting Agenda" (04/18/23) and follow-up email (04/28/23) which demonstrates that MCP staff discussed the 2022 DHCS Medi-Cal Audit Findings and Corrective Action Plans. The MC609 must be completed and sent within 10 business days of

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
		Notification		entering the case in CaseTrack. (Investigation Team Meeting, External Provider Investigations Team email). **MONITORING AND OVERSIGHT EENSUR** • Excel Spreadsheet, "DHCS Report Open and Closed Cases" (06/26/23) to demonstrate that the MCP has a self-monitoring process to track the reporting of suspected fraud and/or abuse to DHCS within ten working days. On a weekly basis, the MCP will review weekly reports of any open and closed FWA cases impacting Medi-Cal members for the previous two-week period (10 business days) to validate timely reporting to DHCS. The reports track the Discovery Date, Initial MC609 Date, and Final MC609 Submitted Date. (DHCS Report_Closed Cases- 2023-06-26, DHCS Report_Open Cases- 2023-06-26, NSIU Monitoring Process and Sample Report Data). **The corrective action plan for finding 6.2.1 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: Tiffany Weisberg
Title: Interim Director, CA Medi-Cal & State Sponsored Programs

Signed by: [Signature on File]
Date: April 25. 2023