CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

December 13, 2024

Tori Gill, Senior Manager, Data Reporting & Audit Management *Via E-mail*
KP Cal, LLC
1800 Harrison St.
Oakland, CA 94612

RE: Department of Health Care Services Medical Audit

Dear Ms. Gill:

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 30, 2023 through November 9, 2023. The audit covered the period from November 1, 2022, through October 31, 2023.

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

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

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

Sincerely,

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

Enclosures: Attachment A (CAP Response Form)

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

Mike Pank, Lead Analyst *Via E-mail*
Audit Monitoring Unit
Process Compliance Section
DHCS - Managed Care Quality and 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: Kaiser Permanente, Cal LLC

Review Period: 11/1/22 – 10/31/23

Audit: Medical Audit

On-site Review: 10/30/23 – 11/9/23

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
1.1.1 Sac **Referral to Transplant Program within 72 Hours** The Plan did not directly refer adult members to a transplant program for an evaluation within 72 hours of the member's specialist identifying the member as a potential candidate for the major organ transplant (MOT).	In response to this finding, the Plan's root cause analysis, and to align with DHCS auditor recommendations and demonstrate compliance with regulatory requirements and contractual obligations, the Plan's remediation actions include the following: **Comprehensive Review | Case Samples** 1. In the Plan's review of the finding details, the Plan took note of DHCS auditor's comments and partnered with Medical Group leadership to conduct an end-to-end comprehensive review of each case sample referenced in the finding detail. Results of the comprehensive review were included in the Plan's Mitigation Response to DHCS. (Completed: 3/8/2024) **Policy Update and DHCS Approval**	1. KFHP Comprehensive Review and Mitigation (Submitted and on file with DHCS 3/8/2024) 2. 1.1.1 SAC MOT V2 Medi-Cal Blood and Marrow and Major Organ Transplants Policy, Section 5.5.1.1 (effective 1/1/2024) 3. 1.1.1 SAC MOT V2 KP Approval Cover Page (electronic signature 1/5/2024) 4. 1.1.1 SAC NCAL Update to Transplant Referral External Order for Medi-Cal	KFHP Comprehensive Review and Mitigation Response (Completed: 3/8/2024) MOT V2 Medi-Cal Blood and Marrow and Major Organ Transplants, Section 5.5.1.1 (Completed w/DHCS Approval: 12/27/23, effective 1/1/2024) NCAL Update to Transplant Referral External Order for Medi-Cal (Completed: 3/27/2024)	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Plan Policy MOT V2 Medi-Cal Blood and Marrow and Major Organ Transplants (1/1/24) has been revised to reflect the 72-hour referral timeframe requirement per APL 21-015 (see Section 5.5.1.1). Policy approved by DHCS - Quality & Health Equity Division. **TRAINING** » Plan developed new/refresher provider education pertaining to the requirements set forth in APL 21-015, including revisions to plan policy and transplant authorization referral timeframes. The implementation date 9/15/24. » The Plan continues to partner with regional chiefs of service and physician leaders in designated specialties/advanced disease management (cardiology, pulmonology, hematology/oncology, gastroenterology/hepatology) conducting education sessions and reminding providers of requirements outlined in APL 21-015 and corresponding revisions to the Plan policy. » Specialty provider education where transplant referral timeline requirement is reviewed and discussed with regional chiefs or

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	2. Reviewed and implemented revisions to Plan policy, *Medi-Cal Blood and Marrow and Major Organ Transplants*, as approved by DHCS on 12/27/2023, to ensure that Plan members identified as potential candidates for Blood and Marrow Transplant (BMT) or Major Organ Transplant (MOT) are referred to a DHCS approved Medi-Cal Center of Excellence (COE) transplant program within 72 hours of the member's treating physician/team identifying the member as a potential candidate for MOT or BMT and receiving all of the necessary information to make a referral to the COE. (Completed: 1/1/2024) **Training and Awareness (**Target Completion: 9/30/2024) 3. Develop and implement new/refresher provider education/training, for referring providers, on the following:	(Completed: 3/27/2024) 5. Training and Awareness (Forthcoming, pending completion by 9/30/2024)	Training and Awareness (Target Completion: 9/30/2024)	physician leads of advanced disease management (cardiology, pulmonology, hematology/oncology, gastroenterology/hepatology) teams. » Specialty physician education aimed at determining the timing of clinical documentation when a member is identified as a potential transplant candidate and creating an order entry for external referral pre-transplant in HealthConnect. The submission of an order entry for external referral pre-transplant in HealthConnect marks the formal notification to the Plan of a potential transplant candidate. **MONITORING AND OVERSIGHT** » Plan submitted a Pre-Transplant Compliance Report that is generated and reviewed weekly by the NCAL Outside Medical Services/Referral Operations Department (OMS). » In addition, a monthly report will be reviewed to monitor referrals to transplant programs are made within 72 hours. » Referrals not meeting compliance, OMS will conduct a root cause analysis and determine/implement timely and appropriate remediation. » January to April 2024 Pre-Transplant Compliance Report indicates all referrals were compliant with referral timelines.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	a. Revisions to Plan policy, *Medi-Cal Blood and Marrow and Major Organ Transplants,* Section 5.5 Transplant Authorization Timeframes, (effective 1/1/2024) b. HealthConnect Tapestry Referral Order Entry Update for Medi-Cal (Completed: 3/27/2024) to ensure updates to the referral transplant external order for Medi-Cal members are made and align with the Plan policy, *Medi-Cal Blood and Marrow and Major Organ Transplants* (effective 1/1/2024)			» Health Connect Tapestry update completed 3/27/24 demonstrates updates for transplant referrals for Medi-Cal aligns with Plan policy. **The corrective action plan for finding 1.1.1 Sac is accepted.**
1.1.1 SD **Referral to Transplant Program within 72 Hours** The Plan did not directly refer adult members to a transplant program	In response to finding 1.1.1, the Plan's root cause analysis, and to align with DHCS auditor recommendations and demonstrate compliance with regulatory requirements and contractual obligations, the Plan's remediation actions include the following:	KFHP Comprehensive Review and Mitigation (*Submitted and on file with DHCS 3/8/2024*)	KFHP Comprehensive Review and Mitigation Response (Completed: 3/8/2024)	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Plan Policy SC.HPHP.060 Medi-Cal Blood and Marrow and Major Organ Transplants (1/1/24) has been revised to reflect the 72 hour referral timeframe requirement per APL 21-015 (see Section

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for an evaluation within 72 hours of the member's specialist identifying the member as a potential candidate for the major organ transplant (MOT).	**Comprehensive Review | Case Samples** 1. In the Plan's review of the finding details, the Plan took note of DHCS auditor's comments and partnered with Medical Group leadership to conduct an end-to-end comprehensive review of each case sample referenced in the finding detail. Results of the comprehensive review were included in the Plan's Mitigation Response to DHCS. (Completed: 3/8/2024) **Policy Update and DHCS Approval** 2. Reviewed and implemented revisions to Plan policy, SC.HPHO.060 *Medi-Cal Blood and Marrow and Major Organ Transplants* (effective 5/13/2022) as updated and approved by DHCS on 12/27/2023, to ensure that Plan members identified as potential candidates for Blood and Marrow Transplant (BMT) or Major Organ Transplant (MOT) are referred	1. 1.1.1 SD SC.HPHO.060 Medi-Cal Blood and Marrow and Major Organ Transplant, Section 5.5.1.1 (effective 1/1/2024) 2. 1.1.1 SD SCAL Update to Transplant Referral External Order for Medi-Cal (3/27/2024) 3. Training and Awareness (Forthcoming, pending completion by 9/30/2024)	SC.HPHO.060 Medi-Cal Blood and Marrow and Major Organ Transplant, Section 5.5.1.1 (Completed w/DHCS Approval: 12/27/2023, effective 1/1/2024) SCAL Update to Transplant Referral External Order for Medi-Cal (Completed: 3/27/2024) Training and Awareness (Target Completion: by 9/30/2024)	5.5.1.1). Policy approved by DHCS - Quality & Health Equity Division. » Plan developed new/refresher provider education pertaining to the requirements set forth in APL 21-015, including revisions to plan policy and transplant authorization referral timeframes. The implementation date 9/15/24. » The Plan continues to partner with regional chiefs of service and physician leaders in designated specialties/advanced disease management (cardiology, pulmonology, hematology/oncology, gastroenterology/hepatology) conducting education sessions and reminding providers of requirements outlined in APL 21-015 and corresponding revisions to the Plan policy. » Specialty provider education where transplant referral timeline requirement is reviewed and discussed with regional chiefs or physician leads of advanced disease management (cardiology, pulmonology, hematology/oncology, gastroenterology/hepatology) teams. » Specialty physician education aimed at determining the timing of clinical documentation when a member is identified as a potential transplant candidate and creating an order entry for external referral pre-transplant in HealthConnect. The submission of an order entry for external referral pre-transplant in

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	to a DHCS approved Medi-Cal Center of Excellence (COE) transplant program within 72 hours of the member's treating physician/team identifying the member as a potential candidate for MOT or BMT and receiving all of the necessary information to make a referral to the COE. (Completed: 1/1/2024) **Training and Awareness** (Target Completion: 9/30/2024) 3. Develop and implement new/refresher provider education/training, for referring providers, on the following: a. Revisions to Plan policy, SC.HPHO.060 *Medi-Cal Blood and Marrow and Major Organ Transplant,* Section 5.5 Transplant Authorization Timeframes, (effective 1/1/2024) b. HealthConnect Tapestry Referral Order Entry Update for Medi-Cal (Completed: 3/27/2024) to ensure			HealthConnect marks the formal notification to the Plan of a potential transplant candidate. **MONITORING AND OVERSIGHT** » Plan submitted a Pre-Transplant Compliance Report that is generated and reviewed weekly by the NCAL Outside Medical Services/Referral Operations Department (OMS). » In addition, a monthly report will be reviewed to monitor referrals to transplant programs are made within 72 hours. » Referrals not meeting compliance, OMS will conduct a root cause analysis and determine/implement timely and appropriate remediation. » January to April 2024 Pre-Transplant Compliance Report indicates all referrals were compliant with referral timelines. » Health Connect Tapestry update completed 3/27/24 demonstrates updates for transplant referrals for Medi-Cal aligns with Plan policy. **The corrective action plan for finding 1.1.1 SD is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	updates to the referral transplant external order for Medi-Cal members are made and align with the Plan policy, SC.HPHO.060 *Medi-Cal Blood and Marrow and Major Organ Transplant* (effective 1/1/2024)			
1.2.1 Sac **Use of Evidence-Based Written Criteria** The Plan did not utilize written criteria that was based on sound medical evidence.	In response to this finding, the Plan's root cause analysis, and to align with DHCS auditor recommendations, the Plan's remediation actions include the following: The Plan's utilization management (UM) program team worked to ensure it utilized written criteria based on sound medical evidence through a statewide project led by Coverage Decision Support Unit (CDSU). The CDSU led statewide project includes updating denial rationale in letters using correct clinical criteria versus coverage criteria for medical necessity denials (MND); improving overall readability of denial letters;	1.2.1 SAC Phase I – Example, EPSDT Denial Including Clinical and EPSDT Criteria Phase II – (Forthcoming, pending completion by 06/30/2024) Phase III – (Forthcoming, pending completion by 9/30/2024)	Phase I - Completed Q4 2023 Phase II – Target Completion: 6/30/2024 Phase III - Target Completion: Go-Live by 9/30/2024	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Example of EPSDT Denial Letter demonstrates the MCP updated its denial letter rationale to demonstrate the clinical criteria is present in medical necessity denials. (1.2.1 SAC Phase I Example EPSDT Denial Including Clinical and EPSDT Criteria) **TRAINING** » 5/17/24 Revised Process for EPSDT Denials, Attendance and Attestation Sheets, and EPSDT Job Aid demonstrate the MCP has trained its staff on the revised process of reviewing against item criteria and EPSDT guidelines. Denial Rationale went live in MCP's claim system on 9/17/24. (CDSU Training_Revised Process for EPSDT Denials_051724, Attendance_CDSU Training_Revised Process for EPSDT Denials_051724, Attestation Forms_CDSU Training_Revised Process for EPSDT Denials_051724)

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	and implementing system automation for a Denial Rationale for Medical Necessity Option, across the following phased approach: ***Phase I*** - Updated denial rationale in letters to ensure clinical criteria is utilized and reflected for medical necessity denials. See example of EPSDT denial where both clinical and EPSDT criteria are listed as a reason for a denial. (Completed Q4 2023) ***Phase II*** – Develop and implement system updates to improve denial letter readability level and ensure readability to the 6th grade level. (Target Completion by 6/30/2024) ***Phase III*** - Implement the "Denial Rational for Medical Necessity Option" to determine if a request will ameliorate the child's condition under EPSDT guidelines. (Target Completion: Go-Live by 9/30/2024)			» Cubby Bed Language Rationale Language demonstrates the Plan has updated its denial rationale for improved reading level. (1.2.1 SAC Cubby Bed Language) **MONITORING AND OVERSIGHT** » CDSU Audit Tool Tracker demonstrates the MCP has a process in place to monitor the use of written criteria by decision makers. A random sample is audited on a monthly basis. (CDSU Audit Tool Tracker_Q1 2024 (Redacted)) **The corrective action plan for finding 1.2.1 Sac is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
1.2.1 SD **Use of Evidence-Based Written Criteria** The Plan did not utilize written criteria that was based on sound medical evidence.	The Plan's review of Contract A17, Exhibit A, Attachment 5(1), finding 1.2.1 with details as included in the DHCS 2023 Final Audit Report, and its denial rationale criteria and processes revealed the Plan's physician reviewers did not always have adequate information on the DME referral to determine if a requested item(s) would ameliorate the child's condition under EPSDT guidelines. **DME Provider Communication** To remediate this finding and address this gap, the Plan's Utilization Management (UM) Program team partnered with the Plan's Durable Medical Equipment (DME) to develop a DME Provider Communication for dissemination to all pediatric ordering providers requiring they include documentation of clinical rationale/justification based on	DME Provider Communication – (Forthcoming pending completion by 5/1/2024) Training - (Forthcoming pending completion by 5/31/2024) Monitoring - (Forthcoming pending completion by 7/1/2024 and Ongoing)	DME Provider Communication – Target Completion: 5/1/2024 Training – Target Completion: 5/31/2024 Monitoring – Target Completion: 7/1/2024 and Ongoing	The following documentation supports the MCP's efforts to correct this finding: **TRAINING** » DME Provider Communication 5/17/24 demonstrates the MCP informed its to pediatric physicians to add verbiage or literature explaining why a DME order will ameliorate a child's condition when ordering under EPSDT guidelines. » Pediatric Physician Reviewer Training 3/22/24 and Attendee List demonstrate the MCP trained its pediatric providers on the necessity for including evidence-based guidance for items that may meet criteria or ameliorate an underlying condition under EPSDT guidelines. » VMC Physician Reviewer Communication 5/26/24 demonstrated the MCP reminded its physician reviewers on utilization of written criteria based on sound medical evidence to review of all the ordering provider's comments as listed on the DME referral including any literature for clinical rationale/justification prior to denying EPSDT requests. **MONITORING AND OVERSIGHT** » DME Weekly Monitoring EPSDT Referrals demonstrates the MCP is monitoring its EPSDT referrals for medical justification. (1.2.1 SD_EPSDT Referrals Weekly Monitoring Tracking (1))

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	literature reviews in the comments section of each DME referral that falls under EPSDT guidelines and that does not have a specific formulary guideline. (Target Completion: 05/01/2024) **Training** Develop and implement new training for the Plan's physician reviewers on utilization of written criteria based on sound medical evidence. The Plan's physician reviewers were trained to ensure review of all the ordering provider's comments as listed on the DME referral including any literature for clinical rationale/justification prior to denying EPSDT requests. (Target Completion: 5/31/2024) **Monitoring** Develop and implement monitoring of DME referrals for documentation of clinical rationale/justification based on literature reviews in the			**The corrective action plan for finding 1.2.1 SD is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	comments section of DME referrals that fall under EPSDT guidelines and that do not have a specific formulary guideline. (Target Completion: 7/1/2024 and Ongoing)			
1.2.2 SD **Provision of Medically Necessary Services through Utilization Management Program** The Plan's utilization management (UM) program did not provide medically necessary covered services to members in a sufficient amount to reasonably achieve their purpose.	The Plan's review of SCAL Prior Authorization samples 9 and 16, and the 2023 DHCS Final Audit Report identified a process gap in the denial review workflow resulting in secondary reviewers not securing and considering justification from ordering providers when the quantities on the referral are greater than the allowable amount prior to rendering a denial decision. The Plan's policy SC.RUM.016: *Utilization Management Denial of Practitioner Requests Services* (effective 3/14/2023) addresses denied requested services on page 7, Section 5.1.4 as follows:	1.2.2 SD SC.RUM.016: Utilization Management Denial of Practitioner Requested Services (Effective 3/14/2023) 1.2.2 SD Updated Medical Necessity Approval & Denial Workflow (Update Completed: 3/22/2024) 1.2.2 SD Medical Necessity Denial Review email notification (Email Sent 3/22/2024)	3/22/2024	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Plan policy "SC.RUM.016: Utilization Management Denial of Practitioner Requested Services" did not require any revisions as policy states ""Any decision to deny a physician requested service or to authorize a service in an amount, duration, or scope that is less than requested by the practitioner based on medical necessity, must be made by, or in consultation with, a physician who has the appropriate clinical expertise in treating the medical condition, performing the procedure or treatment." (SC.RUM.016 - Utilization Management Denial of Practitioner Requested Services, section 5.1.4, page 7) » "2024 - DME Approval & Denial Workflow - 05.15.24" provides guidance to internal staff of the process to follow when reviewing DME requests. The workflow was updated with "If an ordering provider requests a QTY greater than the allowable, then the

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	"*Any decision to deny a physician requested service or to authorize a service in an amount, duration, or scope that is less than requested by the practitioner based on medical necessity, must be made by, or in consultation with, a physician who has the appropriate clinical expertise in treating the medical condition, performing the procedure or treatment.*" In response to this finding, the Plan's Utilization Management (UM) program updated the Plan's Medical Necessity Denial Review Workflow to ensure justification for quantities greater than the allowable amount are secured and considered prior to rendering a denial decision in accordance with Plan policy SC.RUM.016, Section 5.1.4. Secondary reviewers were notified and trained through email communication and discussion in the Durable Medical	1.2.2 SD DME Daily Huddle (Discussion Held: 3/22/2024)		DME clerks need to demonstrate a UMR form is submitted." (2024 – DME Approval & Denial Workflow) **MONITORING AND OVERSIGHT** » "1.2.2 SD_UMR Referrals Weekly Monitoring tracking_73124_083024" demonstrates the monitoring process the Plan has implemented to track weekly service requests. Since implementation, the Plan has seen overall improvements in the workflow verifying that Physicians provide adequate justification for requests that require UMR forms. » Data captured for the week ending 8/31/24: Out of 325 referrals: One referral required a UMR form. One referral did not include initial justification; the provider was sent a follow-up request and responded within 24 hours with the appropriate information. » Data captured for the week ending 9/7/24: Out of 330 referrals: 3 referrals required a UMR form. Two providers included initial justification, and the remaining provider responded within 24 hours with justification.

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	Equipment (DME) Daily Huddle meeting (Completed: 3/22/2024)			**The corrective action plan for finding 1.2.2 SD is accepted.**
1.3.1 Sac **Appeals Decision-Makers** The Plan did not ensure that health care professionals with clinical expertise in treating a condition rendered final decisions for appeals of an adverse benefit determination that was based on lack of medical necessity and appeals involving clinical issues.	Section 5.18 of the Plan's policy CA.MR.003 *California Non-Medicare Grievances and Appeals* (effective 5/1/2024) describes the Plan's quarterly self-monitoring Quality Assurance (QA) program which is used to detect and prevent non-compliance. The Plan's Quality Assurance criteria will be updated (effective 7/1/2024) to remove language stating medical necessity requests fulfilled prior to the decision being rendered through the appeal process do not require physician review. Plan policy CA.MR.003 *California Non-Medicare Grievances and Appeals* was updated as follows: Section 6.5.2.3 - clarifies program representatives may not approve	» 1.3.1 SAC Draft Updated CA.MR.003: California Non-Medicare Grievance and Appeal Policy (Target Completion/ Approvals: 5/1/2024) » 1.3.1 SAC Updated Quality Assurance (QA) Criteria (Effective 7/1/2024) ***Forthcoming upon completion:***	» Policy updates and approvals: 5/1/2024 » Quality Assurance Criteria updates: 7/1/2024 » Communication in staff meetings: 5/1/2024 » Oversight Monitoring: 7/1/2024	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » CA.MR.003 was updated to clarify that Med-Cal medical necessity requests fulfilled prior to the decision being rendered through the grievance and appeals process still require physician review. Policy was approved and implemented on 5/1/24. (1.3.1 SAC Draft Updated CA.MR.003 California Non-Medicare Grievance and Appeal Policy) » Quality Assurance (QA) Criteria was updated to remove language stating medical necessity requests fulfilled prior to the decision being rendered through the appeal process do not require physician review. Implementation 7/1/24. (1.3.1 SAC Updated Quality Assurance (QA) Criteria) **TRAINING** » 4/16/24 Training Presentation demonstrates the MCP has trained its staff on the requirements for appeal decision making. (1.3.1 Sac_Staff Meeting Presentation_DHCS Finding_Decision Making Requirements)

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	requests requiring a physician's review even in the event the request is fulfilled prior to the review/decision making process. The Plan will implement monitoring appeals against the policy and QA criteria updates to ensure decisions on appeals of adverse benefit determinations based on medical necessity and/or involving clinical issues are rendered by a physician. (Target implementation by 7/1/2024). Additionally, staff meetings will be held to review the DHCS findings and decision-making requirements. (Target start date: 5/1/2024)	» Staff meeting presentation » Staff meeting sign-in sheets Final/ Approved CA.MR.003: California Non-Medicare Grievance and Appeal Policy		**MONITORING AND OVERSIGHT** » QA Compliance Monitoring Program describes the MCP's weekly process steps and development of a quarterly report and variance reports for underperforming metrics. Medi-Cal appeals are monitored against Plan policy CA.MR.003 California Non-Medicare Grievances and Appeals Section 6.5.2.3 and the updated Quality Assurance (QA) criteria to demonstrate decisions on appeals of adverse benefit determinations based on medical necessity and/or involving clinical issues are rendered by a physician. MCP provided results of this metric for Q3 2024. **The corrective action plan for finding 1.3.1 Sac is accepted.**
1.5.1 Sac **Timeliness of UM Decisions for Timeframe Extensions** The Plan did not ensure its delegate,	During the 2023 DHCS audit interview the Plan's delegate, American Specialty Health (ASH), discovered reviews of Medi-Cal routine prior authorization requests were inadvertently tracked under ASH's *Medical Necessity Review (MNR) Report*, rather than ASH's	» Screen shot of the programming correction request and completion date time stamp. Please refer to document	11/15/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Screenshot of delegate's programming correction request and completion date time stamp demonstrates the MCP's delegate updated its system to allow 28 days from authorization requests

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
ASH, rendered decisions for routine prior authorization requests with timeframe extensions within 28 calendar days.	*Medicare and Medi-Cal Extension Pending Report*. ASH utilizes its MNR Report to monitor transactions for all lines of business, as a result, the MNR Report allows pending cases for up to 45 calendar days, thereby not aligning to the Medi-Cal requirement to not pend authorizations beyond 28 days. ASH's Medicare and Medi-Cal Extension Pending Report allows pending cases for up to 28 calendar days, in alignment with Medi-Cal requirements. Following this discovery, ASH reviewed the issue and identified the root cause as a programming error. ASH corrected the programming error by moving the review of Medi-Cal routine prior authorization requests from their MNR Report to their Medicare and Medi-Cal Extension Pending Report.	1.5.1_Supporting Documentation » Updated Medicare and Medi-Cal Extension Pending Report template attached (Excel). Please refer to document 1.5.1 Medicare and Medi-Cal Extension Pending Report » 1.5.1 SAC UM008.2 Statewide KP-ASH Matrix 2022-2023 » 1.5.1 SAC KPNC Delegation of UM Activities for Delegate Entities		that are extended. Correction took place 11/15/23. (1.5.1_Supporting Documentation) **MONITORING AND OVERSIGHT** » UM008.2 Statewide KP-ASH Matrix 2022-2023 and KPNC Delegation of UM Activities for Delegated Entities demonstrates the MCP process in place to monitor its delegates UM program on an annual basis including the monitoring of timeframes. » Medicare and Medi-Cal Extension Pending Report from 5/15/24 demonstrate the delegate monitors its routine authorizations with a report that aligns with the Medi-Cal timeliness requirement of 28 days. (Medicare and Medi-Cal Extension Pend Report 5.15.2024) **The corrective action for finding 1.5.1 Sac is accepted.**

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	The programming correction was completed and effectuated on 11/15/2023. ASH's Medicare and Medi-Cal Extension Pending Report is generated and monitored daily by ASH's Senior Data Entry Examiners to ensure decisions for all Medi-Cal routine prior authorization are rendered timely. The Plan ensures oversight of ASH through its Annual Delegation Audit. Oversight responsibilities are outlined in the Plan's policy: KPNC Delegation of UM Activities for Delegate Entities Policy (effective 5/1/2023), and the 2022-2023 Delineation of Delegation Responsibility Matrix American Specialty Health. The Plan's 2023 Annual Delegation Audit of ASH is underway; results will be summarized by 9/30/2024.	Policy (effective 5/1/2023)		
1.5.1 SD	During the 2023 DHCS audit interview the Plan's delegate,	» Screen shot of the programming	11/15/2023	The following documentation supports the MCP's efforts to correct this finding:

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
Timeliness of UM Decisions for Timeframe Extensions The Plan did not ensure its delegate, ASH, rendered decisions for routine prior authorization requests with timeframe extensions within 28 calendar days.	American Specialty Health (ASH), discovered reviews of Medi-Cal routine prior authorization requests were inadvertently tracked under ASH's *Medical Necessity Review (MNR) Report*, rather than ASH's *Medicare and Medi-Cal Extension Pending Report*. ASH utilizes its MNR Report to monitor transactions for all lines of business, as a result, the MNR Report allows pending cases for up to 45 calendar days, thereby not aligning to the Medi-Cal requirement to not pend authorizations beyond 28 days. ASH's Medicare and Medi-Cal Extension Pending Report allows pending cases for up to 28 calendar days, in alignment with Medi-Cal requirements. Following this discovery, ASH reviewed the issue and identified the root cause as a programming error. ASH corrected the programming	correction request and completion date time stamp. Please refer to document 1.5.1_Supporting Documentation » Updated Medicare and Medi-Cal Extension Pending Report template attached (Excel). Please refer to document 1.5.1 Medicare and Medi-Cal Extension Pending Report » 1.5.1 UM008.2 Statewide KP-		**POLICIES AND PROCEDURES** » Screenshot of delegate's programming correction request and completion date time stamp demonstrates the MCP's delegate updated its system to allow 28 days from authorization requests that are extended. Correction took place 11/15/23. (1.5.1_Supporting Documentation) **MONITORING AND OVERSIGHT** » UM008.2 Statewide KP-ASH Matrix 2022-2023 and SC.RUM.033 Delegation of UM Activities the MCP process in place to monitor its delegates UM program on an annual basis including the monitoring of timeframes. » Medicare and Medi-Cal Extension Pending Report from 5/15/24 demonstrate the delegate monitors its routine authorizations with a report that aligns with the Medi-Cal timeliness requirement of 28 days. (Medicare and Medi-Cal Extension Pend Report 5.15.2024) **The corrective action for finding 1.5.1 SD is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	error by moving the review of Medi-Cal routine prior authorization requests from their MNR Report to their Medicare and Medi-Cal Extension Pending Report. The programming correction was completed and effectuated on 11/15/2023. ASH's Medicare and Medi-Cal Extension Pending Report is generated and monitored daily by ASH's Senior Data Entry Examiners to ensure decisions for all Medi-Cal routine prior authorization are rendered timely. The Plan ensures oversight of ASH through its Annual Delegation Audit. Oversight responsibilities are outlined in the Plan's policy: SC.RUM.033 Delegation of UM Activities Policy (effective 5/22/2023), and the 2022-2023 Delineation of Delegation Responsibility Matrix American Specialty Health. The Plan's 2023 Annual Delegation Audit of	ASH Matrix 2022-2023 » 1.5.1 SD SC.RUM.033 Delegation of UM Activities Final 5		

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	ASH is underway; results will be summarized by 9/30/2024.			

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 SD **Family Planning Payments** The Plan did not pay add-on payments for specified family planning claims in accordance with APL 22-011.	**System Configuration Update** The Prop 56 add-on logic was updated to include service line codes that had been previously denied as bundled to the contract provider's rate and ensure providers are paid the Prop 56 add-on payment in accordance with the requirements set forth in APL 22-011. (Completed: 3/8/2024). **Remediated Claims** Four of five of the San Diego GMC Family Planning (FP) sample claims identified for audit period November 1, 2022, through October 31, 2023, as well as subsequent dates through March 7, 2024, were remediated and payment disbursed to impacted providers following the Plan's Prop 56 add-on logic update. (Completed: 3/25/2024).	» 3.6.1 SD Prop 56 add-on logic updated screenshots » 3.6.1 SD Remediation Tracker Family Planning Samples #1, 5, 6, and 10 (not submitted due to PHI)	» Updated Prop 56 add-on logic – Completed: 3/8/2024 » Remediation and Provider Payments for San Diego GMC Family Planning (FP) Samples 1, 5, 6, and 10 – Completed: 3/25/2024	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Screenshot, "Prop 56 add-on logic updated screenshots" to demonstrate that Prop 56 add-on logic was updated on March 8, 2024, to include codes that had been previously denied as bundled to the contract provider's rate. Logic now includes denial remark codes CED11 and INWCG that are used to deny a service line inclusive to the case rate. (SD_Prop 56 add-on logic updated screenshots). **MONITORING AND OVERSIGHT** » "CLD-85 Monitoring Report" (March 2024) to demonstrate that the MCP updated the control report logic to ensure that add-on payments are paid to providers who were paid a bundled rate. The updated logic has been incorporated into the Plan's quarterly monitoring process and report to validate Prop 56 transactions which include Family Planning claims. (CLD-85 Monitoring Report - March 2024). » "NCAL and SCAL Prop 56 Quarter 2, 2024" Monitoring Report to demonstrate that the MCP has implemented a monitoring process to ensure that add-on payments are paid to providers who were paid a bundled rate. The Quarter 2, 2024 Quarterly Monitoring

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				report includes the updated logic that add-on payments are paid to providers who were paid a bundled rate. The Quarterly Monitoring Report also tracks the Region, Reason to Deny Line, Code Billed, Prop 56 Paid Date, Values Count of Region, Sum of Prop 56 Paid Amount. (NCAL SCAL Prop 56 Q2 Monitoring Report). **The corrective action plan for finding 3.6.1 SD is accepted.**
3.6.2 SD **Denial of Family Planning Services Claims** The Plan improperly denied family planning services claims.	**Impact Analysis/Review** The Plan conducted a 1-year look-back of all Medi-Cal claims denied due to an invalid diagnosis code. The resulting validation report revealed that two (2) Family Planning (FP) services claims were improperly denied due to a configuration issue in the Plan's Claim System (Tapestry). (Completed: 3/6/2024) **Remediated Claims** The two (2) identified FP services claims were reviewed and	» 3.6.2 SD Family Planning Validation Report from 3.6.23 through 3.6.24, for reviewed/remediated claims (not submitted due to PHI) » 3.6.2 SD Family Planning Monitoring Rpt, for monthly monitoring	» Validation Report - Completed: 3/6/2024 » Monitoring - 4/30/2024 and ongoing » System Configuration Research - TBD pending guidance from DHCS	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » P&P, "POL-005: Payments to Providers" (7/11/22) which 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. **MONITORING AND OVERSIGHT** » "CLD-85 Monitoring Report" (May 2024) to demonstrate that the MCP is conducting monthly monitoring to identify additional improperly denied family planning services claims for reprocessing to verify proper adjudication. (CLD-85 Monitoring Report- May 2024).

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	remediated as included on the," 3.6.2 SD Family Planning Validation Report from 3.6.23 through 3.6.24," Column I. (Completed: 3/6/2024) **Monitoring** To ensure FP services claims with valid diagnosis codes are properly adjudicated, the Plan will implement monitoring through a monthly monitoring report to identify, overturn, and properly adjudicate all FP service claims improperly denied due to invalid diagnosis codes. (Target Completion: 4/30/2024 and Ongoing) **System Configuration Research** In the Plan's review of the finding details, the Plan took note of the DHCS auditor's comments and began researching feasible system configuration options for automation and/or related process enhancements as a long-term			» The MCP adheres to the CMS guidance as outlined in the Medicare and Medicaid Services Pub 100-04 (p. 2/section I.B.) and Centers for Medicare and Medicaid Services Standard Companion Guide Version No. 3.0 (p. 13/ Health Care Diagnosis Code). DHCS acknowledges that the MCP adheres to the CMS guidance as outlined in the Medicare and Medicaid Services Pub 100-04 (p. 2/section I.B.) and Centers for Medicare and Medicaid Services Standard Companion Guide Version No. 3.0 (p. 13/ Health Care Diagnosis Code). **The corrective action plan for finding 3.6.2 SD is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	approach to maintaining compliance. To inform the Plan's research, the Plan is seeking guidance from DHCS on the following as related to the DHCS auditor's comments: Rule evidence for paying individual diagnosis codes at claim line level with an invalid header level diagnosis rather than denying the entire claim. The plan is seeking clarification/guidance from DHCS as this practice does not follow CMS ICD-10 industry standards. (Target completion: TBD pending guidance from DHCS.)			

4. Member's Rights

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
4.1.1 Sac **Provision of Medically Necessary Services through the Grievance Program** The Plan did not provide medically necessary covered services to members for requests that originated from grievances.	Kaiser Foundation Health Plan, Inc. ("KFHP" or "the Plan") is committed to addressing the identified deficiency and root cause to ensure full compliance with regulatory and contractual requirements through the following: **New/Refresh Training** 1. Develop new or refresh existing investigative review (IR) training to ensure clinical reviewers provide investigative responses and information that clarifies how clinical observations, tests, parent reports, and	» 4.1.1 SAC DHCS-EPSDT-Provider-Training » 4.1.1 SAC Rehabilitation Leaders and Clinicians Refresh Training: (completed 4/12/2024) » 4.1.1 SAC Rehabilitation leaders and clinicians refresh training sign in sheet (4/12/2024) » 4.1.1 SAC Rehabilitation leaders and clinicians refresh training follow up email. (4/15/2024) » IR training forthcoming: implementation by 9/30/2024 » Draft Updated CA.MR.003: California Non-Medicare Grievance and Appeal Policy (Target Completion/ Approvals: 5/1/2024)	» DHCS EPSDT Provider Training (ongoing and biennially thereafter; initial annual attestation submitted to DHCS February 2024) » Rehabilitation Leaders and Clinicians Refresh Training: 4/12/2024 » Policy updates and approvals: 5/1/2024 » Communication in staff meetings: 5/1/2024	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Revised P&P, "CA.MR.003: California Non-Medicare Grievances and Appeals Policy" (05/01/24) demonstrates the MCP revised Section 7.46.1 to include a definition of medical necessity for EPSDT covered services. As well, the provision of medically necessary services, requested through grievance processor or otherwise, is the member rights addressed in the Plan's Evidence of Coverage. (CA.MR.003 California Non-Medicare Grievances and Appeals Policy.pdf) and (Medi-Cal_2024_EOC.pdf) **MONITORING AND OVERSIGHT** » Audit Results, EPSDT Grievance and Appeal Review, (Audit Period 07/01/24 - 09/30/24) demonstrates the MCP has performed an audit to make certain decision makers provide medically necessary services to children according to Medi-Cal EPSDT guidelines. 48 Grievances and Appeals were clinically screened against the following audit checklist questions: 1. Does letter contain elements/criteria related to medical necessity of request?

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	standardized tests align to develop a unique integrated Plan of Care for children, addressing, monitoring, and/or ameliorating significant impairments in collaboration with Rehabilitation and Behavioral Health Therapies. (Target completion by 9/30/2024) 2. Continue Medi-Cal Training on EPSDT Benefit for Medi-Cal Members under Age 21 leveraging DHCS EPSDT Provider Training modules. (Ongoing and as required by DHCS) 3. Development and implementation of training refresh sessions for rehabilitation			2. Does letter contain reference to whether item was evaluated under EPSDT guidelines? » 7 out of 48 notices were identified for services that were not covered/excluded per the member's EOC. 41 notices remaining. 38/41 were compliant with the two questions above. 3/41 were non-compliant with the two questions above. The compliance rate was 92.6%, indicating a high level of adherence to the required standards and guidelines. » Audit Schedule, "EPSDT Grievance & Appeals Review" (Audit Period 04/01/24 - 09/30/24) demonstrates the MCP has deployed their monitoring processes. » Monitoring Tool, "Audit Tool" (Audit Period 04/01/24 - 09/30/24) demonstrates the MCP is ensuring the resolution letter contains elements/criteria related to medical necessity of request and references to whether item was evaluated under EPSDT guidelines. **TRAINING** » Training, "Medi-Cal for Kids & Teens Provider Training" (On-going and biennially thereafter) demonstrates the MCP provides on-going training to its Providers' to make certain that they have an understanding of EPSDT criteria defining medical necessity of care and requirement monitoring. In addition, attestations provided. (4.1.1 SAC DHCS-EPSDT-

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	clinicians (including Rehabilitation Leaders) to emphasize guidelines for documenting the rationale behind the Plan of Care. (Completed: 4/12/2024) **Policy Update and Dissemination:** 1. Update to the Plan's policy, CA.MR.003 *California Non-Medicare Grievances and Appeals Policy*, Section 7.46.1, to include a definition of "medical necessity" for EPSDT covered services. (Effective: 5/1/2024) 2. The Plan's Member Relations team will communicate this policy update to review regulatory requirements and raise awareness of the findings in an			Provider-Training.pdf) and (KFHP Network Providers Completed EPSDT Training_20240215.pdf) » Escalation Process, "Escalation for Completion of KP Learn Module" (06/25/24) demonstrates the MCP has completed a timeline for Providers to complete the KP Learn Module. » E-Mail, "Medi-Cal Training on EPSDT Benefits for Medi-Cal Members under Age 21" (02/15/24) demonstrates the MCP informed the Rehab Service Director – KPNC, that a learning module is available that can be helpful in understanding the new Medi-Cal contract as it pertains to developmental screening. » Training, "Rehabilitation Leaders and Clinicians Refresh Training" (04/12/24) demonstrates the MCP developed and implemented training refresh sessions for rehabilitation clinicians (including Rehabilitation Leaders) to emphasize guidelines for documenting the rationale behind the Plan of Care. In addition, attestations received for the refresher training. (4.1.1 SAC Rehabilitation Leaders and Clinician Refresh Training.pptx and 4.1.1 SAC Rehabilitation leaders and clinicians refresh training sign in sheet.txt) » Training, "Investigative Review (IR) Training" (Implementation date 09/15/24) demonstrates the MCP is providing medically necessary services to members for requests that originated from grievances through training on review of the proper

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	upcoming staff meeting. (Target Completion 5/1/2024)			documentation of medical necessity. Additionally, to ensure clinical reviewers provide investigative responses and information that clarifies how clinical observations, tests, parent reports, and standardized tests align to develop a unique integrated Plan of Care for children, addressing, monitoring, and/or ameliorating significant impairments in collaboration with Rehabilitation and Behavioral Health Therapies. (GA IR Guidance_Final.pptx) » Short-term - The Plan in collaboration with the Permanente Medical Group (TPMG) will streamline provider training requirements and develop an escalation path to Associate Physician in Charge (APICs), Chiefs, and Associate Executive Director (AEDs), alerting them to providers that are non-compliant with completing the required DHCS EPSDT Provider Training by 6/30/24. **The corrective action for finding 4.1.1 Sac is accepted.**

5. Quality Management

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
5.1.1 Sac **Evaluation and Action for Potential Quality Issues** The Plan did not evaluate and take effective action to address needed improvements in quality of care and access to services; the Plan was not accountable for the evaluation and resolution of issues relating to quality of covered services.	***For SAMPLES #1-5:*** In response to this finding, the Plan's root cause analysis, and to align with DHCS auditor recommendations, the Plan's remediation actions include the following: **Desk Level Procedure (DLP)** The NCAL Regional Practitioner Performance Review and Oversight (PPRO) committee will develop and implement a Desk Level Procedure (DLP) to support adherence to the Plan's policies *CA.SCQC.QOC.002 Health Plan Review Department Quality Concerns* (effective 1/11/2023) and	» 5.1.1 SAC CA.SCQC.QOC.002 Kaiser Foundation Health Plan Review Department Quality Concerns Policy » 5.1.1 SAC CA.QOC.SCQC.003 Peer Review and Evaluation of Licensed Independent Practitioner Performance » 5.1.1 SAC 2022 Quality Program Description for Northern California Region » 5.1.1 SAC 2023 Quality Program Description for Northern California Region » 5.1.1 SAC 2024 Health Plan Oversight of Peer Review for Northern California	**Desk Level Procedure (DLP):** -Development - Targeted Completion: 6/30/2024 -Implementation - Target completion: 9/30/2024 **Training and Awareness -** Target Completion: 9/30/2024 **Monitoring** – currently in place and ongoing ***SAMPLE #1 (22-6540):*** Direct Referral Review Process – Target Completion: 9/30/2024 ***SAMPLE #4 (22-6027):*** Out Sick –Helping Reschedule Instructions (Workflow implemented Q2 2024)	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » P&P, CA.SCQC.QOC.005, "Monitoring and Assessments of Quality Process" (02/01/17) demonstrates the MCP's responsibility and accountability for the evaluation and resolution of issues related to QOC services. » Newly Developed Desk Level Procedure, "Northern California DLP to Facilitate Application of Health Plan Policies" (08/21/24) (Implementation Date 09/19/24) which demonstrates the MCP evaluates and takes effective action to address needed improvements in Quality Oversight Committee (QOC), access to services, and ensures Plan accountability for evaluation and resolution of issues related to quality of covered services. » Updated Procedures, "Out Sick Helping Reschedule" (04/11/24) demonstrates the MCP has updated its Psychiatry Department workflow to require a manager, or designee, to proactively follow up with members beginning the second consecutive day a therapist is out, regardless of whether the member attempts to contact the department. » Updated Job Aid, "SAC NVLYSB221MANAGERREVIEW Timeframe Job Aid" (04/05/24) demonstrates the MCP has

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	CA.QOC.SCQC.003 Peer Review and Evaluation of Licensed Independent Practitioner Performance (effective 1/1/2023). Once finalized and approved, the PPRO Committee will implement and disseminate the DLP to all Chiefs of Quality, Area Safety and Quality Officers and Quality staff. (Target Completion: 9/30/2024) **Training and Awareness:** Training sessions will be conducted to review the newly implemented Desk Level Procedure (DLP), as disseminated, with impacted staff including all Chiefs of Quality, Area Quality Leaders and Quality staff with emphasis on understanding the	***SAMPLE #1 (22-6540):*** 5.1.1 SAC CA.QOC.SCQC.003 Peer Review and Evaluation of Licensed Independent Practitioner Performance ***SAMPLE #4 (22-6027):*** **Process | Workflow:** 5.1.1 SAC Out Sick-Helping Reschedule Instructions (updated 4/11/2024) **Process | Documentation** *5.1.1 SAC NVLYSB221MANAGERREVIEW Timeframe Job Aid*	**Process | Documentation** Implemented 6/30/2023; NVLYSB221MANAGERREVIEW Timeframe Job Aid last updated 4/5/2024	implemented documentation standard changes that require the provider document SB221 recommended timeframe for follow up appointments and if they are unable to book within the recommend timeframe, the provider will consult with a Behavioral Health Manager (BHM). **MONITORING AND OVERSIGHT** » Oversight, "2024 Health Plan Oversight of Peer Review for Northern California" (03/25/24) demonstrates the MCP continues its existing oversight and monitoring through evaluation and resolution of issues related to quality of covered services. » 2022 Quality Program Description for Northern California Region and 2023 Quality Program Description for Northern California Region demonstrates the Plan continues its existing oversight and monitoring through evaluation and resolution of issues related to quality of covered services. **TRAINING** » Training, "Awareness Training" (Targeted Completion Date 09/30/24) demonstrates the MCP will conduct a training on the newly implemented Desk Level Procedure with staff including all Chiefs of Quality, Area Quality Leaders and Quality Staff. **The corrective action plan for finding 5.1.1 Sac is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	importance of adherence to Plan policies and role clarification to ensure alignment with DHCS auditor recommendations. (Target Completion: 9/30/2024) **Quality Program Description and Annual Review** Additionally, in the Plan's review of the finding details, the Plan took note of DHCS auditor's comments. To ensure compliance with CCR, Title 28, section 1300.70, the Plan reviewed its *2022 Quality Program Description for Northern California Region,* as approved by DHCS on 6/6/2023 to meet a Readiness Deliverable for			

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	the 1/1/2024 Direct Contract. While the statute indicates it "*is not intended to set forth a prescriptive approach to QA methodology*" rather it "*is intended to afford each plan flexibility in meeting Act quality of care requirements*", the Plan validated that its QA program addresses the "*service elements, including accessibility, availability, and continuity of care*", as per statute, and includes ongoing monitoring to ensure "t*he provision and utilization of services meet professionally recognized standards of practice*" as required under CCR, Title			

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	28, section 1300.70. (Completed: 4/1/2024) The Plan conducts an annual review of its *Quality Program Description for Northern California Region* and makes necessary updates to ensure compliance with regulatory requirements and contractual obligations across all lines of business. The Plan has made updates to its *2022 Quality Program Description for Northern California Region* for 2023. (Completed: 4/12/2023) Note, the *2022 & 2023 Quality Program Description for Northern California Region* were included in the Plan's 2023 DHCS pre-audit submission.			

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	Monitoring The Plan continues its existing oversight and monitoring through evaluation and resolution of issues related to quality of covered services by conducting annual Regional Clinical Oversight Assessments (RCOA) through parallel workstreams as follows: 1. Peer review cases from each medical center, assessment results, and corrective action plans, if applicable, are discussed and approved by the Practitioner Performance Review and Oversight (PPRO) committee.			

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	2. Department review cases from each medical center are assessed by a Health Plan Quality nurse consultant. Assessment results and any needed corrective action plans are discussed and approved by the Practitioner Performance Review and Oversight (PPRO) committee. 3. Focus Practice Review Oversight Committee meeting minutes from each local service area are reviewed by members of the PPRO committee as described in the *2024 Health Plan Oversight*			

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	of Peer Review for Northern California. ***SAMPLE #1 (22-6540):*** **Direct Referral Review Process** All Direct Referrals will be thoroughly reviewed by the Chief of Quality (COQ)/Assistant Chief of Quality (ACOQ) to: » identify all providers and departments related to the potential quality of care allegation(s) » ensure that all quality issues are identified, and the appropriate providers are attributed, all quality issues are addressed, and members receive safe and effective care in accordance with the			

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	Plan's Desk Level Procedure (DLP) and corresponding DLP training and awareness activities. (Target Completion: 9/30/2024) ***SAMPLE #4 (22-6027):*** **Process | Workflow** The Plan proactively notified the member in advance of the cancellation with instructions to contact the NVLY BH Department to reschedule. Previously, therapists were expected to follow up with their cancelled members for their missed appointments within two business days of their return to work. The Plan updated its workflow			

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	(outlined below) to require a manager, or designee, to proactively follow up with members beginning the second consecutive day a therapist is out, regardless of whether the member attempts to contact the department. Follow-up is defined as an outreach call to the member's phone number on file to verbally communicate the cancellation of the appointment and to offer the member to reschedule. Should the member be unavailable, a voicemail will be left inviting the member to call the Mental Health & Wellness Department main line at (916) 973-			

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	5300 to reschedule when they are available. Additionally, a secure message will be sent to the member's kp.org account, informing member of the cancellation with instructions to call the main department line to reschedule. The established therapist will follow up with their cancelled member the next business day. For example, if a therapist is out unexpectedly on a Monday and Tuesday, on Tuesday, a BHM, or designee, will contact the impacted members (that had their Monday appointments cancelled), regardless of whether			

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	they contacted the department to reschedule. In the event a therapist is out for an extended period of time, such as a medical leave, emails will be routed to their manager or designee's KP Health Connect inbox to monitor messages directly from members. **Process | Documentation** The NVLY BH Department has implemented documentation standard changes that require the provider document SB221 recommended timeframe for follow up appointments and if they are unable to book within the recommend timeframe, the provider will consult with a			

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	Behavioral Health Manager (BHM). BHMs document in the member's chart using KP Health Connect Smart Phrase *NVLYSB221MANAGERREVIEW*. (Completed: 4/5/2024) Requests for Clinically Indicated Sooner Appointments (CISA) are handled by a therapist's direct BHM or identified BHM. Appointments conducted by Connect-to-Care (C2C), that are in need of a follow up CISA, are now routed to the respective location edit pool in Kaiser Permanente Health Connect (KPHC) (Roseville/Sacramento) with oversight and			

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	management by an identified BHM. Should a therapist or appointment with a member's therapist be unavailable within the SB221 recommended timeframe, therapy services could be bridged by another available therapist.			
5.1.1 SD **Evaluation and Action for Potential Quality Issues** The Plan did not evaluate and take effective action to address needed improvements in quality of care and access to services;	***For SAMPLES #1-5:*** In response to this finding, the Plan's root cause analysis, and to align with DHCS auditor recommendations, the Plan's remediation actions include the following: **Desk Level Procedure (DLP)** The SCAL Regional System and Peer Review	» 5.1.1 SD CA.SCQC.QOC.002 Kaiser Foundation Health Plan, Review Department Quality Concerns Policy » 5.1.1 SD CA.QOC.SCQC.003 Peer Review and Evaluation of Licensed Independent Practitioner Performance » 5.1.1 SD 2022 Quality Program Description for	**Desk Level Procedure (DLP)** » Development - Targeted Completion: 6/30/2024 » Implementation - Target completion: 9/30/2024 **Training and Awareness** –	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » P&P, CA.SCQC.QOC.005, "Monitoring and Assessments of Quality Process" (02/01/17) which describes Plan responsibility and accountability for the evaluation and resolution of issues related to QOC services. » Newly Developed Desk Level Procedure, "Southern California DLP to Facilitate Application of Health Plan Policies" (08/21/24) (Implementation Date 09/19/24) which demonstrates the Plan evaluates and takes effective action to address needed improvements in Quality Oversight

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
the Plan was not accountable for the evaluation and resolution of issues relating to quality of covered services.	Oversight Committee (RSPROC) will develop a Desk Level Procedure (DLP) to support adherence to the Plan's policies *CA.SCQC.QOC.002 Kaiser Foundation Health Plan, Inc. Review Department Quality Concerns* (effective 2/15/2023) and *CA.QOC.SCQC.003 Peer Review and Evaluation of Licensed Independent Practitioner Performance* (effective 02/15/2023). Once finalized and approved, the DLP will be disseminated to all Assistant Administrators of Quality, Quality Physician Leaders, and Quality Directors. (Target Completion of Dissemination: 9/30/2024)	the Southern California Region » 5.1.1 SD 2023 Quality Program Description for the Southern California Region » 5.1.1 SD 2024 Health Plan Oversight of SCAL Peer Review **Training** » 5.1.1 SD Phase I Proof of Training » 5.1.1 SD Phase 2 Proof of Training » 5.1.1 SD Phase 1 Training Slides » 5.1.1 SD Phase 2 Training Slides » 5.1.1 SD TAT Training Attendees **Monitoring**	» Target Completion: 9/30/2024 **Monitoring –** currently in place and ongoing **Training** » Phase I Training for Nursing Staff – Completed: Q4 2023 » Phase II Training for Nursing Staff – Target Completion: 6/30/2024 » Phase I Training for Clerical Staff – Target Completion: 6/30/2024 » Phase II Training for Clerical Staff – Target Completion by 10/1/2024 **Process** » Development of 2024 SD PQI IRR Checklist *(Updates to 2023 Checklist)* - (Target	Committee (QOC), access to services, and ensures Plan accountability for evaluation and resolution of issues related to quality of covered services. » Revised Process, "2023 PQI IRR Checklist" (06/30/24) demonstrates the MCP revised and disseminated to San Diego Local Quality Department staff, an updated 2023 SD PQI IRR Checklist with improvements to prioritize and ensure that all quality issues in the referral source are clearly identified and described with appropriate questions to the department under review. **MONITORING AND OVERSIGHT** » Oversight, "2024 Health Plan Oversight of Peer Review for Northern California" (03/25/24) demonstrates the MCP continues its existing oversight and monitoring through evaluation and resolution of issues related to quality of covered services. » 2022 Quality Program Description for Southern California Region and 2023 Quality Program Description for Southern California Region demonstrates the Plan continues its existing oversight and monitoring through evaluation and resolution of issues related to quality of covered services. » BH Trend Access Report (07/2023 - 10/2023) Continued monthly generation and review of Trended Access Reports by the SCPMG Service and Access Committee to monitor

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	Training and Awareness Training sessions will be conducted to review the newly implemented DLP with impacted staff including all Assistant Administrators of Quality, Quality Physician Leaders, and Quality Directors with emphasis on understanding the importance of adherence to Plan policies and role clarification to ensure alignment with DHCS auditor recommendations. (Target Completion: 9/30/2024) **Quality Program Description & Annual Review** Additionally, in the Plan's review of the finding details, the Plan took note of DHCS auditor's	» 5.1.1 SD BH trended access report 07.2023 to 10.2023 » 5.1.1 SD November 30, 2023 Messaging Committee Minutes TAT **Process** 5.1.1 SD 2023 PQI IRR Checklist	Completion: 6/30/2024) **Training and Implementation** (Target Completion: 9/30/2024) **Monitoring** 11/30/2023 and ongoing	appointment booking within standard guidelines and ensure members' timely access to appointments after cancellation and timely responses to member messages. » Committee Minutes, "Messaging Committee Meeting Minutes (11/30/23) demonstrates the MCP established a Messaging Committee to develop, refine, and monitor workflows and messaging efficiencies. **TRAINING** » Training, "Proof of Training Phase 1 (Nursing Staff Q4 2023 and Clerical Staff 06/30/24) and Proof of Training Phase 2 (Nursing Staff 06/30/24 and Clerical Staff 09/19/24) demonstrates the MCP developed and implemented department-wide training on turnaround time (TAT) targets to reinforce TAT targets and expectations for timely responses to member messages. Training, "Awareness Training" (Targeted Completion Date 09/30/24) demonstrates the MCP will conduct a training on the newly implemented Desk Level Procedure with staff including all Chiefs of Quality, Area Quality Leaders and Quality Staff. **The corrective action plan for finding 5.1.1 SD is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	comments. To ensure compliance with CCR, Title 28, section 1300.70, the Plan reviewed its 2022 Quality Program Description for Southern California Region, as approved by DHCS on 6/6/2023 to meet a Readiness Deliverable for the 1/1/2024 Direct Contract. While the statute indicates it "*is not intended to set forth a prescriptive approach to QA methodology*" rather it "*is intended to afford each plan flexibility in meeting Act quality of care requirements*", the Plan validated that its QA program addresses the "*service elements, including accessibility,*			

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	availability, and continuity of care", as per statute, and includes ongoing monitoring to ensure "t*he provision and utilization of services meet professionally recognized standards of practice*" as required under CCR, Title 28, section 1300.70. (Completed: 4/1/2024) The Plan conducts an annual review of its *Quality Program Description for Southern California Region* and makes necessary updates to ensure compliance with regulatory requirements and contractual obligations across all lines of business. The Plan has made updates to its *Quality Program Description for Southern*			

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	California Region for 2023. (Completed: 6/30/2023) Note, the *2022 & 2023 Quality Program Description for Southern California Region* were included in the Plan's 2023 DHCS pre-audit submission. **Monitoring** Lastly, the Plan continues its oversight and monitoring through evaluation and resolution of issues related to quality of covered services by conducting annual Regional Clinical Oversight Assessments (RCOA) through parallel workstreams as follows: 1. Peer review cases from each medical			

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	center, assessment results, and corrective action plans, if applicable, are discussed and approved by the Regional System and Peer Review Oversight Committee (RSPROC). 2. Department review cases from each medical center are assessed by a Health Plan Quality nurse consultant. Assessment results and any needed corrective action plans are discussed and approved by RSPROC as referenced in *Health Plan Oversight of SCAL Peer Review.* ***SAMPLE #2 (23-1543):***			

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	The Plan determined that its SCAL Regional Behavioral Health team is accountable for appointment turnaround times and its San Diego Local Quality Department team is accountable for the Inter-Rater Reliability (IRR) process. The IRR process ensures that all quality issues in the referral source are clearly identified and described, including questions applicable to the department under review. In response to this finding, and identified process gap, remediation efforts by the Plan's San Diego (SD) Psychiatry department, which reports into the Plan's SCAL Regional Behavioral			

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	Health team, include the following: **Staffing** Initiated hiring process for physicians and registered nurses and implemented maximum utilization of Per Diem physicians. (Completed: 12/31/2023 and Ongoing) **Processes** » Reviewed the Plan's San Diego Psychiatry Department's appointment rescheduling and message management protocols. (Completed: 12/31/2023) » Protected time in physician schedules to ensure appointment times were reserved and made available for			

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	timely rescheduling when appointments were cancelled. (Completed: 3/31/2024) **Training** Developed and implemented department-wide training on turnaround time (TAT) targets to reinforce TAT targets and expectations for timely responses to member messages. **Monitoring** » Continued monthly generation and review of Trended Access Reports by the SCPMG Service and Access Committee to monitor appointment booking within standard guidelines and ensure			

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	members' timely access to appointments after cancellation and timely responses to member messages. (Completed: 12/31/2023 and Ongoing) » Established a Messaging Committee to develop, refine, and monitor workflows and messaging efficiencies. (Completed: 12/31/2023 and Ongoing) IRR remediation actions by the Plan's San Diego Local Quality Department team include the following: **Process** » Reviewed current Inter-Rater Reliability			

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	(IRR) processes for improvement opportunities (Completed: 3/31/24) » Revise and disseminate to San Diego Local Quality Department staff, an updated *2023 SD PQI IRR Checklist* with improvements to prioritize and ensure that all quality issues in the referral source are clearly identified and described with appropriate questions to the department under review. (Target Completion: 6/30/2024) **Training and Implementation** Training sessions will be conducted to review the			

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	revised *2023 SD PQI IRR Checklist*, as disseminated, with San Diego Local Quality Department staff to implement the updated IRR Checklist, emphasizing the importance of the updated IRR Checklist and how to effectively utilize Checklist. (Target Completion: 9/30/2024) **Monitoring** Continue monitoring of the IRR process in through two oversight bodies: San Diego Local Quality Department and Department Review Oversight Committee			

6. Administrative and Organizational Capacity

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
6.2.1 Sac Records Retention The Plan did not ensure all Medi-Cal-related records and documents were maintained for the required ten-year retention timeframe.	In response to this finding, the Plan's root cause analysis, and to align with DHCS auditor recommendations, the Plan's remediation actions include the following: **Training and Awareness** 1. Disseminate and review finding 6.2.1 and Plan policy NATL.EC.005 *Business Record Retention: Appendix B* (effective 6/10/2022) Plan procedures, E-mail Retention Rules (implemented 2020), to impacted departments to ensure awareness of federal record retention requirements specific to Medi-Cal-related records and documents be maintained for ten years. (Target Completion: 6/30/2024) 2. Complete a policy refresh review with impacted departments to inform and educate the department staff on the existing indefinite e-mail retention	1. Training and Awareness (Forthcoming, pending completion by 6/30/2024) 2. Policy Updates (Forthcoming, pending completion by 6/30/2024) 3. Process (Forthcoming, pending completion by 6/30/2024) 4. Monitoring (Forthcoming, pending completion by 9/30/2024)	1. Training and Awareness (Target Completion: by 6/30/2024) 2. Policy Updates (Target Completion: by 6/30/2024) 3. Process (Target Completion: by 6/30/2024) 4. Monitoring (Target Completion by 9/30/2024)	The following documentation supports the MCP's efforts to correct this finding: The Plan cited that Plan Procedures, E-mail Retention Rules (implemented 2020), revealed the root cause was a gap in training and awareness on the Plan's procedures, including email retention rules implemented by the Plan in 2020 to ensure adherence to regulatory requirements and contractual obligations to maintain Medi-Cal related records for ten years. **POLICIES AND PROCEDURES** » Plan Policy, "Business Record Retention" Policy Number NATL.EC.005, Effective Date 06/10/2022, Appendix B, Bullet 1. "Medicare and Medicaid Records" (page 7), already included language stating that the Plan must retain all ensure Medi-Cal-related records and documents are maintained for ten years or until the completion of a government audit, whichever is later. (Business Record Retention Policy NATL.EC.005) » The Plan provided documentation that an IT Ticket was submitted to the Plan's IT Department on April 17, 2024, to designate and set retention configuration rules to the affected departments, Quality and Psychiatry, and was completed and closed by IT Department on April 26, 2024. This updated retention rule configuration addresses the gap that contributed to the audit finding. (IT Ticket #6285116

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	options and customized retention configuration rules to ensure compliance with Medi-Cal record retention requirements. (Target Completion: 6/30/2024) **Policy Updates** 3. Review, revise, and implement updates to Plan department level policies, *Review Department Quality Concerns* and *Peer Review and Evaluation of Licensed Independent Practitioner Performance* to include the retention policy statement. (Target Completion: 6/30/2024) **Process** 4. Designate the shared folders the department uses as "never delete" using customized retention configuration rules (Target Completion: 6/30/2024 5. Develop and implement a process redundancy for saving all supporting documentation to each PQI in PDF			4.24 and RITM6285116 has been Closed Complete _ Shared Mailbox & Calendar.msg) **TRAINING** » KP Learning Training Module demonstrates, via screenshots of the Plan's "Business Record Retention Portal," that online/website/video training was provided to staff, which was updated to include records retention process and the Plan's "never delete" retention process in section 3. TOOLKIT: Records Retention (pages 13-14). (6.2.1 SAC Training Module_Retention Rules Website_Retention Rules and Toolkit) **MONITORING AND OVERSIGHT** » The Plan developed and established an audit tool to maintain ongoing compliance of the Plan's retention of emails within the Quality Department Shared Mailboxes process. The audits of the shared Outlook mailboxes used by the affected departments are performed monthly. The results of the audits are monitored and overseen by the Plan's Medicaid Medical Director. (6.2.1 SAC_2023 DHCS Annual Audit Finding 6.2.1 SAC CAP Response Documentation 8-27-24) » The Plan provided samples of the Outlook Shared Mailboxes Audit, which includes sections for storing and retaining records and documents for ten years. (6.2.1 SAC_S.SAC ROS Business

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	format and uploading it into the Plan's internal documentation tracking system, MIDAS. (Target Completion: 6/30/2024) **Monitoring** 6. Establish oversight and monitoring processes to ensure compliance with federal record retention requirements for Medi-Cal related records and documents, Medi-Cal contractual obligations, and Plan policies and protocol. (Target Completion: 9/30/2024)			Record.Email Retention Audits 8.2024 SIGNED and 6.2.1 SAC_SAC Business Record.Email Retention Audits 8.2024 SIGNED) **The corrective action plan for finding 6.2.1 Sac 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: ___Tori Gill_____

Title: _Manager, Medicaid Health Plan Compliance, Kaiser Permanente_

Signed by: __[Signatures on file]____

Meryl Katz, Executive Director, Medicaid Health Plan Compliance, **Amanda Flaum,** Vice President of California and Hawaii Medicaid

Date: ____4/19/2024_____