March 2, 2023

Jane MacAdam, Director of Compliance & Regulatory Affairs
Kern Health System
2900 Buck Owens Boulevard
Bakersfield, CA 93308

RE: Department of Health Care Services Medical Audit

Dear Ms. MacAdam:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Kern Health System, a Managed Care Plan (MCP), from September 13, 2021 through September 24, 2021. The audit covered the period of August 1, 2019 through July 31, 2021.

All items have been evaluated and DHCS accepts 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 report and the enclosed documents 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]

Oksana Meyer, MPA
Chief, CAP Compliance & FSR Oversight Section
Managed Care Quality & Monitoring Division
Department of Health Care Services

Enclosures: Attachment A (CAP Response Form)

cc: Lyubov Poonka, Chief
CAP Compliance Unit
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Department of Health Care Services

Maria Angel, Lead Analyst
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Lucas Patton, Contract Manager
Medi-Cal Managed Care Division
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ATTACHMENT A
Corrective Action Plan Response Form

Plan: Kern Family Health Care **Review Period: 08/01/19 – 07/31/21**

Audit Type: Medical Audit and State Supported Services **Onsite Review: 09/13/21 – 09/24/21**

MCPs are required to provide a CAP and respond to all documented deficiencies 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 that will reduce turnaround time for DHCS to complete its review. According to ADA requirement, 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, and the operational results of that action. The MCP shall directly address each deficiency component by completing the following columns provided for MCP response: 2. Action Taken, 3. Implementation Documentation, and 4. Completion/Expected Completion Date. The MCP will be required to include project timeline with milestones in a separate document for each finding. Supporting documentation should accompany each Action Taken. For policies and other documentation that have been revised, please highlight the new relevant text. For deficiencies that require short-term corrective action, implementation 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 completely remedy or operationalize, the MCP is to indicate that it has initiated remedial action and is on the way towards achieving an acceptable level of compliance. In those instances, the MCP will be required in addition to the above steps, to include the date when full compliance will be achieved. **Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval, as applicable in accordance with existing requirements.**

DHCS will maintain close communication with the MCP throughout the CAP process and provide technical assistance to ensure the MCP provides sufficient documentation to correct deficiencies. Depending on the volume and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates, as applicable.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
1. Utilization Management				
1.1.1 Approval of Medically Necessary Covered Services The Plan did not ensure appropriate processes were used to review and approve the provision of medically necessary covered services. The Plan did not ensure that medical procedures approved were medically necessary. **Recommendation:** Revise and implement policies and procedures to ensure appropriate processes are used to review and approve the provision of medically necessary covered services.	Prior to the audit, KHS had processes in place to ensure approval of medically necessary services, as outlined in Policy 3.22-P. The finding was specific to an auto-approval process implemented during the audit timeframe, and the need to ensure services approved through that process were medically necessary. 1. Revisions have been made to our policies, 3.22-P and 3.25-P to expand on the process and confirm authorizations approved through this process will be sampled during the Utilization Management quarterly audit process. Policy 3.25-P has also been updated to include additional information related to the auto approval process. It is	1. 3.22-P 1. 3.25-P	1. 03/10/2022 1. 03/10/2022	The following documentation supports the MCP's efforts to correct this finding: **Policies & Procedures:** - Policy 3.25-P was updated to describe the MCP's temporary auto approval process as well as its quarterly monitoring process used to monitor the auto approval process. The temporary process can only be implemented on a limited-term basis by the Chief Medical Officer or their designee. The purpose of the temporary program is to mitigate any impact to the turnaround times for authorization requests due to high service request volumes or holiday office closures. (Page2) **Monitoring and Oversight:** - Quarterly Provider Over and/or Underutilization Tool is used to conduct quarterly audits or random samples to review for medical necessity. - Compliance Departmental Monitoring Tracking Tool used to track completion of medical necessity audits. - Auto Approval Audit from Q1 2022 demonstrates the MCP actively monitors referrals for auto-approval for medical necessity. **The Corrective Action Plan for Finding 1.1.1 is accepted.**

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	important to note that those going through the no prior auth/Auto auth process will validate any code selected for consideration is a covered benefit. 2. Utilization Management will be conducting a new random sample quarterly audit of services that have been auto approved to review for medical necessity and present findings in QI/UM Committee. 3. Compliance created tracking tool to monitor for completion of Medical Necessity Audits	2. Kern Health Systems Utilization Management Department Quarterly Provider Over and/or Underutilization Tool 3. Compliance Departmental Monitoring Tracking Tool	2. Complete Q1 audit in Q2 2022 and report out in QI-UM May 2022 3. 03/09/2022	
1.1.2 Under and Over-Utilization of Health Care Services The Plan did not have systematic methods including policies and procedures for	Although KHS did conduct over and under-utilization activities prior to audit, we did not have sufficient documentation in policies or reporting. We have updated our policies and developed			The following documentation supports the MCP's efforts to correct this finding: **Policies and Procedures:** **-** Policy 3.22-P – Referral and Authorization Process was updated to define the MCP's over and underutilization process which

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detecting under- and over-utilization of health care services. **Recommendation:** Develop and implement comprehensive and systematic methods including policies and procedures for detecting under- and over-utilization of services throughout the Plan.	systematic methods as outlined below: **<u>Underutilization</u>** 1. Revise and develop process to utilize open auth/fulfillment report by PCP/Non-PCP 2. Update 3.22 to define underutilization process 3. Implementing new process to send notification to providers advising of open authorizations for which we have not received a claim 4. Re-education to provider on the location and availability in the provider portal of KHS provider profile (2D) reports that enable our contracted	1. See open auth letter and provider bulletin below 2. 3.22-P 3. Open Authorization Letter Template Provider Bulletin for underutilization 4. Provider Portal_Provider Profile_Example	1. 03/2022 2. 03/2022 3. Q2 2022 4. 04/2022	includes monthly utilization and cost metrics for all major service groups by aid category, to determine if performance meets expectation. KHS compares practice patterns for similar diagnosis (within the same specialty) to identify inconsistencies. **Education / Implementation:** **-** Utilization Review Provider Bulletin / Open Authorization Letter Template informs providers about open authorization requests and reminder to schedule the member's open authorization requests. - Provider Portal Profile example used by PCPs to conduct peer to peer comparison to other network provider across multiple disciplines. **Monitoring:** - Quarterly audit tool which will be used to audit 30 medical records for auth closures to identify potential underutilization. Audits to begin Q1 2022. - UM Program Description was updated to include definition of over and underutilization. The MCP reports monthly utilization and cost metrics for all major service groups by aid category, to determine if performance meets expectation. Quarterly, the MCP compares for both PCP and Specialists practice patterns for similar diagnosis.

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	PCP network to conduct self-service, peer-to-peer comparison to other network providers across several disciplines, including practice demographics, Inpatient, MCAS/HEDIS, Pharmacy, Utilization, Clinical engagement, COVID 19 statistics, and member condition profile. The 2D profile provides a holistic view of each PCPs practice patterns, gaps in members care, and member specific program enrollment. Some sections are PCP specific and require entry of member information to access. Additionally, member risk scores and downloadable member list options prompt PCPs to determine outreach for completion of services.		5. Complete Q1 audit in Q2 2022 and	The UM Program Description also describes the MCP's monitoring of under and over-utilization. • The UM department monitors underutilization of health service activities through collaboration with the QI department. • Over-utilization of services is monitored through several functions. Reports are reviewed to analyze unfulfilled authorizations or gaps in care to determine interventions directed to ameliorate any identified adverse trends. • Audits for over and underutilization are performed to identify any potential fraud, waste, and abuse. • Utilization across all UM functions are evaluated to determine if fraud, waste, abuse, or quality concerns warrant investigation. Suspected or identified fraud, waste, and abuse is reported to the Compliance department within five (5) days for investigation to determine if additional actions are required, and subsequently reported quarterly to QI/UM Committee - *Ambulatory Overutilization Report* serves as an example of self-service report for potential overutilization. - UM Meeting Minutes from 2/2/22 serve as evidence the MCP discussed its over and underutilization process and that staff is reviewing for medical necessity and to review MCAL guidelines prior to MCG. - Compliance Departmental Monitoring Tracking Tool was created to track the completion of over / under utilization audits.

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	5. Utilization Management will complete a quarterly audit of 30 medical records for auth closure that identifies potential underutilization and present findings in QI/UM Committee 6. Update UM program description **<u>Overutilization</u>** 7. Revise policy 3.22-P to define overutilization process 8. Implementation of self-service reporting for identification of potential overutilization 9. Utilization Management will complete a quarterly audit of 30 charts using internal dashboard that identifies potential overutilization and	5. Kern Health Systems Utilization Management Department Quarterly Provider Over and/or Underutilization Tool 6. UM Program Description 7. 3.22-P 8. Sample Self-Service Report 9. Kern Health Systems Utilization	report out in QI-UM May 2022 6. 03/2022 7. 03/2022 8. 03/2022 9. Complete Q1 audit in Q2 2022 and report out in QI-UM May 2022	- Q1 2022 UM Department OP Referral Audit demonstrates the MCP is actively monitoring for over and underutilization. **The Corrective Action Plan for Finding 1.1.2 is accepted.**

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	present findings in QI/UM Committee. 10. Discussion of over/under-utilization in monthly UM Meeting 11. Compliance created tracking tool to monitor for completion of Over/Under-Utilization Audits.	Management Department Quarterly Provider Over and/or Underutilization Tool 10. UM Monthly Meeting Minutes 2.2.22 11. Compliance Departmental Monitoring Tracking Tool	10. 02/2/2022 11. 03/09/2022	
1.1.3 Written Member Letters The Plan did not have policies and procedures to ensure member information is provided to members at a sixth grade reading level.	1. Health Education department expanded licenses for health literacy tool to medical directors and conducted training.	1. Reading Level Assessment Tool Screenshot 1a. License Example 1b. Training	1. 02/2022	The following documentation supports the MCP's efforts to correct this finding: **Policies:** Policy 3.2.2 Referral and Authorization Process was updated to detail the MPCS's process for checking readability level. Upon generation of a written member informing material, the UM staff enters the text into the health literacy assessment tool. If the

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Recommendation: Develop and implement policies and procedures to ensure all written materials are provided to members are clear, concise, and at a sixth grade reading level.	2. 60 + letter templates for frequently used outpatient NOA letters completely transitioned to be written in 6th grade reading level 3. CDC plain language thesaurus shared with health services team for reference as needed in letter creation to explain medical terminology. 4. Utilization Management Audit Tools updated to include checking for reading level; Audit results will be reported in QI/UM Committee 5. Compliance Audit Tools updated to include checking for reading level.	Meetings for use of tool 2. Revised frequently used template examples 3. Thesaurus document 4. Utilization Management Audit Tools for Delayed, Denied, Modified Audits 5. Compliance Audit Tools (Member	2. 02/2022 3. 02/2022 4. Complete Q1 audit in Q2 2022 and report out in QI-UM May 2022 5. 03/09/2022	material is scored above the 6th grade reading level, the UM staff uses the tool to identify the technical or high literacy terms and replaces these terms with the suggested lower literacy terms provided by the health literacy assessment tool or the plain language terminology resources. (page 11) **Implementation / Training:** - Health Literacy Adviser Tool is now available to medical directors. Screenshot, license invoice training invite and attendance provided. - CDC Plain Language Thesaurus used to assist in the use of creating easier to understand letters. **Monitoring & Oversight:** - Examples of letter templates written at 6th grade reading level. - CDC Plain Language Thesaurus used to assist in the use of creating easier to understand letters. - Updated UM Audit tools include field for monitoring reading level. - Policy 3.22 was updated to include monitoring methods. Random audits will be conducted by the MCP on a quarterly basis. The Director of Compliance will conduct semiannual random audit related to member notification. (page 22)

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		Appeals, Grievances, Provider Appeals)		- Compliance Appeal and Denial Auditing Tools updated to include a field to check for reading level. - UM Denied Referral Audit Q1 2022 demonstrates the MCP regularly audits its letter for readability. **The Corrective Action Plan for Finding 1.1.3 is accepted.**
1.2.1 Written Criteria or Guidelines for Medical Prior Authorizations The Plan did not consistently apply Medi-Cal criteria when processing prior authorization requests. In some cases, the Plan prioritized MCG instead of Medi-Cal criteria. **Recommendation:** Develop and implement policies and procedures to ensure that all UM	1. Policy 3.22-P updated to include hierarchy of criteria to use: • Medi-Cal • MCG • Up2Date • Professional Society guidelines 2. UM program description updated to list criteria hierarchy to use Medi-Cal criteria first. 3. Utilization Management updated audit tools to include reviewing for use of Medi-Cal criteria/correct hierarchy	1. 3.22-P 2. UM Program Description added language 3. Utilization Management Audit Example –	1. 03/2022 2. 03/2022 3. Complete Q1 audit in Q2 2022 and report out in	The following documentation supports the MCP's efforts to correct this deficiency: **Policies:** Updated Policy: 3.22P – Referral and Authorization Process (3/22). Section 7.0 Criteria ad Guidelines was revised to indicate Medi-Cal Guidelines – DHCS/DMHC as the first criteria to be used for decision making. Milliman Care Guidelines are listed as the second applicable criteria. Updated Utilization Management Program Description (2021) indicates the MCP utilizes approved sources to make decisions based on medical necessity. Decisions are outlined in state regulatory guidelines and law. Clinical guidelines are available as a guide for medical necessity decisions. Hierarchy for consistent application of medical necessity criteria: Medi-Cal Guidelines are listed first.

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staff uses Medi-Cal criteria first to make medical authorization decisions. Criteria should be based on sound medical evidence, consistently applied, regularly reviewed, and updated.	of criteria used; results of audits will be reported in quarterly QI/UM Committee. 4. Risk Management PPT education provided to UM staff on decision-making and discussed in dept meeting w/ staff attestations. 5. Risk Management PPT has been added to the training and onboarding materials. 6. Discussion of correct application of Medi-Cal criteria in monthly UM Meeting 7. Compliance Audit Tools updated to include checking for Medi-Cal criteria in letters	UM Internal Denial Tool 4. Risk mgmt. PPT; blank attestation form; and signature sheets 6. UM Monthly Meeting Minutes 7. Compliance Audit Tools (Member Appeals, Grievances, Provider Appeals)	QI-UM May 2022 4. 02/2022 6. 02/02/2022 7. 3/09/2022	**Monitoring & Oversight:** Revised audit tools include review of whether clinical criteria used is correct/appropriate. Also includes notation that Medi-Cal guidelines are to be used first. Utilization Management Monthly meeting (2/22) demonstrates evidence that medical necessity reviews are utilizing Medi-Cal guidelines prior to Milliman Care Guidelines. **The Corrective Action Plan for Finding 1.2.1 is accepted.**

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2. Case Management and Coordination of Care				
2.1.1 Comprehensive Initial Health Assessment (IHA) Completion Plan did not ensure completion of comprehensive IHAs, to include documentation of comprehensive history, SHA, and colorectal, cervical, and blood lead screens. The Plan did not adhere to its policies and procedures and did not monitor the completion of IHAs. **Recommendation:** Implement policies and procedures to ensure completion of comprehensive IHAs. Develop a monitoring system including	KHS had numerous processes in place surrounding encouraging members to complete the Initial Health Assessment through new member letters, new member welcome calls, and member incentives. In addition, we had established provider incentives and provider education. We have created a new policy to fully document activities associated with Initial Health Assessments, and enhanced our monitoring activities, as outlined within the policy and itemized below: 1. New Policy created to fully document IHA activities and incorporate new processes for monitoring IHAs including USPTFS/Bright Futures	1. New IHA Policy	1. 03/04/2022	The following documentation supports the MCP's efforts to correct this finding: **Policies and Procedures:** Draft Policy – Initial Health Assessment (and monitoring activities) The policy describes the Initial Health Assessment (IHA) requirements and associated monitoring activities of Kern Health Systems (KHS) and its contracted Primary Care Providers (PCPs). **Policy:** Contracted PCPs are responsible for the completion and documentation of IHAs within 120 calendar days of a member's enrollment with the Plan, which include an age-appropriate Individual Health Education Behavioral Assessment (IHEBA), pursuant to the standards outlined in Attachment A, Guidelines for Completing the Initial Health Assessment and MMCD Policy Letter: No. 08-003. PCPs must administer the Staying Healthy Assessment (SHA) or other DHCS-approved IHEBA as part of the IHA, and re-administer at age appropriate intervals thereafter to all new members, including SPD members. All newly enrolled members must receive an IHA within 120 days of enrollment (DHCS Policy Letter 08-003). A minimum of three

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proper staffing to ensure these policies and procedures are implemented and effective.	preventive health services. 2. The previous IHA report has been updated and will be utilized for provider notification to ensure awareness of new members that have not completed the IHA. 3. A notification letter created for monthly distribution to providers with guidance to locate list of members who are non-compliant with IHA within 120 days. 4. KHS provides a new	2. IHA Member Compliance Report (Production report, but PHI removed) 3. IHA Policy X.X Attachment B -IHA Provider Letter 3a. IHA Provider Portal Screenshot	2. 03/07/2022 3. 3/07/2022; Implementation of letters no later than April 4. 2021	documented attempts must be made to schedule the IHA, including at least one phone call and one letter. Documentation of this visit and assessment must be made in the patient's medical record and include all age-appropriate physical evaluation elements. **Implementation:** MCP deployed: New member call script-Discuss importance of HRA, How to access member portal, Verify contact information, PCP assignment Assist in scheduling initial IHA within the first 120 days of enrollment Member Rewards (Incentive) Program IHA within 120 days; Completion of HRA; Scheduled IHA within 120 days of becoming a member Pay for Performance Program – 2022 Provider incentives – providers are automatically enrolled 11 different measures, including screenings, well child, and IHA completion Provider Manual Updates Section 4 – UM Program IHA – completed with 120 days If IHA not present in medical record the reason must be documented, including member refusal, missed appointments, etc.

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	member letter, covers the IHA during the welcome call, and provides member incentives for IHA completion. 5. Provider incentives for IHA is part of our pay-for-performance (P4P) program. 6. Provider education is provided within our provider manual and provider portal 7. Member education is provided on the KHS member portal. 8. A review of the monthly IHA compliance reports has been added to QI-UM agenda for future meetings.	4. Welcome Call Script; New Member Letter; Member Rewards Letter 5. KHS_2022 P4P Binder Final 6. KHS Provider Manual Excerpt and Provider Portal screenshot 7. IHA Member Portal Screenshot	5. 1/2022 6. 1/2022 7. 1/2022 8. May 2022 9. 07/1/2022	IHA Member Portal Health Care Reminder Screenshot of member home page Health care reminders – reminds members to complete IHA within 120 days and availability of obtaining a gift card. **Monitoring & Oversight:** The Plan has developed and deployed an internal auditing process and implemented additional measures, including member and provider informing materials and incentive programs. The Plan produced the following documentation: IHA Report Monthly provider scorecard (compliant and non-compliant providers) IHA Provider Template letter Advises providers how many members assigned to their practice haven't completed an IHA since enrolling. Directs provider to log into Provider Portal to identify members that haven't completed IHA and work with them to complete an IHA within the required timeframe. Provider Portal Update (screenshot shared) Allows providers to view/export/print list of non-compliant members assigned to their practice.

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	9. A new semi-annual medical record audit of providers will occur in July (January through June) and January (July through December). This audit will be conducted by QI staff for monitoring of IHA/SHA/IHEBA and provider notification, as outlined within the policy. 10. Medical Record Review audit results will be reported to QI-UM Committee. 11. Compliance created tracking tool to monitor completion of Medical Record Review Audit	8. QI-UM Committee Agenda for Q1 2022 reporting 9. IHA Policy X.X Attachment C - Bi-Annual Audit Tool IHA Policy X.X Attachment D - Educational Letter for IHA Preventive Services Audit 10. Medical record audit results for Q2 2022	10. 07/2022; reporting to QI/UM Committee in September 11. 03/09/2022	1. The listing is updated monthly. The list includes specific member PHI as well as Enrollment date, IHA Due Date, PCP name and Provider ID. **Monitoring & Oversight:** The Plan has established and has deployed various monitoring and/or internal auditing processes to ensure complete and timely IHAs. Medical record review portion of Provider Site Reviews Review will consist of IHA documentation, including use of the SHA/IHEBA. When non-compliance with regulatory requirements are identified, the Site Review nurse will educate the provider on the requirements and may issue a corrective action plan. Plan runs monthly reports of members who are non-compliant with the requirement for an IHA and sends educational and information letters to the assigned PCP. Provider letter template includes the following: Summary of non-compliance Outline of requirements Resources available Conducts bi-annual audits of PCPs to evaluate whether all components of an IHA have been completed and are documented in accordance with regulatory requirements.

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		Q2 QI-UM Committee Meeting Report 11. Compliance Departmental Monitoring Tracking Tool		<u>Bi-annual audit tool – IHA/Preventive Health Services (medical records) includes review of the following:</u> -Complete medical records review -Adult, pediatrics, including blood lead measures documentation in medical record -Screenings -Immunization status -Member refusal, missed appointments -SHA -Documents non-compliant providers A new semi-annual medical record audit of providers will occur in July (January through June) and January (July through December). This audit will be conducted by QI staff for monitoring of IHA/SHA/IHEBA and provider notification, as outlined within the policy. Medical Record Review audit results will be reported to QI-UM Committee. (7/22) The Plan submitted evidence of internal audits for the first two quarters of 2022, including examples of a provider education letter and CAP. Initial bi-annual audit was completed, 100 medical records were reviewed and submitted to DHCS 8/29/22. **The Corrective Action Plan for Finding 2.1.1 is accepted.**

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3. Access and Availability of Care				
3.8.1 NEMT/NMT Providers Medi-Cal Enrollment Status The Plan did not ensure NEMT/NMT providers were enrolled in the Medi-Cal program. The Plan did not monitor pending enrollment of transportation providers into the Medi-Cal program. **Recommendation:** Revise and implement policy and procedure to ensure all transportation providers are enrolled in the Medi-Cal program.	1. Kern Health Systems Policy and Procedure *4.43-P Medi-Cal Enrollment Policy* states "Kern Health Systems (KHS) requires that all plan contracted providers enroll in the Medi-Cal Program. … KHS will verify DHCS Medi-Cal FFS Enrollment through California Health and Human Services (CHHS) Open Data Portal." Prior, and during, the Plan's DHCS 2021 medical audit, all of the Plan's network of contracted transportation providers were Medi-Cal enrolled via the DHCS screening and enrollment process or in the process of Medi-Cal enrollment via the DHCS screen and enrollment process; the Plan maintained ongoing	1. KHS Policy *4.43-P Medi-Cal Enrollment Policy*	1. Previously implemented	The MCP submitted the following supporting documentation: **Policies & Procedures:** The Plan updated P&Ps to address the gap that contributed to the deficiency: - P&P "5.15-P Member Transportation Assistance" demonstrates the Plan has processes in place for both transportation brokers & providers to ensure they are meeting all DHCS requirements set forth in APL 22-008. The Plan will allow providers to participate in its network during the application process for up to 120-days. The Plan will terminate its contract with the provider when denied and/or expiration of the 120-day period. [5.15-P, ENROLLMENT Section 10.0, Page #10-11] **Implementation/Oversight & Monitoring:** The Plan identified, developed and deployed an internal auditing process to continuously self-monitor to detect and prevent future non-compliance: • Provider Roster "Transportation Provider Roster – KHS_20221014" demonstrates the Plan is tracking & monitoring the enrollment of transportation brokers & providers in the Medi-Cal program. The Plan validates this roster monthly to verify Medi-Cal enrollment. This transportation monitoring report is provided to the Plan's Compliance Department

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	monitoring of these provider's Medi-Cal enrollment status. At that time, the Plan was also in the process of ongoing communication with the DHCS' Managed Care Quality and Monitoring Division regarding the enrollment status of its transportation providers, including reporting that captured the in-progress/pending enrollment status of applicable transportation providers. In efforts to maintain its network of transportation providers and to ensure access to transportation services to Plan membership, the Plan remained contracted with transportation providers outside the 120-day window outlined in APL 19-004 as these providers awaited enrollment decisions from			monthly by its Provider Network Management team to ensure compliance. The roster has been verified & the cited transportation providers from the report are all enrolled in the Medi-Cal program. [See 10-14-22 MCP Response] • P&P "5.15-P Member Transportation Assistance" demonstrates the Plan will be tracking that the transportation broker & providers are complying with all requirements set forth in APL 22-008, ensuring monitoring activities are performed no less than quarterly, including but not limited to Enrollment Status. The Plan will impose corrective action on its transportation brokers & providers who are found to be out of compliance with the requirements. [5.15-P, Monitoring and Oversight Section 10.3, Page #10-11] **The Corrective Action Plan for Finding 3.8.1 is accepted.**

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	the DHCS or prepared reenrollment submissions. 2. Following the audit, the Plan terminated the contracts for those transportation providers who received a denial letter from DHCS. 3. As of January 2022, all but two (2) of the Plan's contracted transportation providers were enrolled via the DHCS screening and enrollment process. Regarding the two (2) pending providers, the Plan reached out to the DHCS and was informed by the DHCS Managed Care Quality and Monitoring Division on January 25, 2022 that they are "not looking for MCPs to terminate	2. Screen print of terminated transportation providers *3.* 1/25/2022 & 02/02/2022 DHCS MCQMD E-mail, Subject: *RE: [External]Kern Health Systems - Transportation Roster Guidance* 4. Transportation Provider Roster	2. Referenced provider contracts were terminated Q4 2021 3. Monitoring of provider's enrollment status remains ongoing as outlined in *Action Taken.* 4. 03/04/2022	

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	contracts" and to "not terminate the contract." 4. The Plan maintains monthly ongoing monitoring of all network providers' enrollment status; regarding the two (2) providers referenced above with pending enrollment statuses: one (1) was given 60-days to correct deficiencies, were subsequently completed, and has been approved per DHCS letter dated 2/17/2022, and one (1) provider remains pending. A new monthly report is being provided go Compliance to monitor compliance with enrollment status requirement.			
4. Member Rights				

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
4.1.1 Classification of Quality of Care Grievances as Exempt Grievances The Plan did not ensure grievances were accurately classified as QOC and misclassified them as exempt grievances. Consequently, these grievances were not referred, investigated, and reviewed by a Medical Director as required. **Recommendation:** Revise and implement policies and procedures to ensure grievances are accurately classified, and that QOC grievances are reviewed by the Medical Director and properly resolved.	1. All grievances received will be disseminated to the Grievance Committee members (including QI RN and Medical Director) for validation of classification type. No grievance will be closed as “Exempt” without review by a QI RN and medical director. 2. Policy 5.01-I has been updated to align with the new processes in 2.70-I Potential Quality of Care Issue (PQI) Policy 3. Grievance Job Aid created 4. New Grievance Workflow created to address correct classification and handling of Quality of Care Grievances 5. Compliance will conduct	1. 2.70-I Potential Quality of Care Issue (PQI) Policy Draft 2. 5.01-I Grievance Policy 3. Grievance Job Aid 4. QOC Grievance Workflow	1. 03/21/2022 2. 03/21/2022 3. 03/03/2022 4. 03/21/2022 5. Audit to begin in May 2022 & be reported	The following documentation supports the MCP’s efforts to correct this deficiency: **Policies and Procedures:** - Revised and Drafted P&P, “2.70-I: Potential Quality of Care Issues” (Effective 07/01/22) which is being revised to include procedures in regard to all PQI referrals that are screened by a QI RN to validate that a PQI exists and documents clinical summary of their review. If PQI may be present, QI RN will forward to Medical Director - Revised and Drafted P&P, “5.01-I: KHS Member Grievance and Appeal System (Revised 03/04/22) was revised to ensure grievances are accurately classified, and the QOC grievance are reviewed and resolved by the Medical Director. - Job Aid, “Grievance Process” (02/22) which ensures grievances are accurately classified as QOC and are referred and reviewed by a Medical Director. **Monitoring/Tracking:** - Workflow, “KHS Potential Quality of Care Grievance Review Process” (03/07/22) as evidence to address accurate classification and managing of QOC grievances. - Audit Tool, “Potential Quality of Care Issue (PQI) Audit Tool” (02/27/22) audits quarterly for the following:

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	a monthly review of QOC grievances and report results to the Compliance Committee 6. Quality Department will conduct a quarterly audit of the QI review of the grievances to ensure appropriate QI processes followed	5. Compliance Exempt Grievance Audit Results 6. 2.70-I Potential Quality of Care Issue (PQI) Policy Attachment A Audit Tool Template	in following Compliance Committee mtg 6. Q3 2022	• Does the SBAR capture appropriate information to classify accurately • Appropriate decision made to refer or not refer to Medical Director **Training:** - Meeting, Microsoft Team Meeting, "Grievance Process Update" (03/17/22) and attendance summary with names of participants. This meeting was held to address that grievance coordinators are sending all grievances (both exempt and standard) to the quality team to review as of 03/21/22. This is a new process to ensure that no potential QOC grievances are closed as exempt. - Meeting, Microsoft Team Meeting, "MD Grievance Review Meeting" (03/17/22) which addressed the exempt grievances will be included in reviews. - Meeting, Microsoft Team Meeting, "QI Grievance Process Review" (03/18/22) which addressed, all exempt and standard grievances must be reviewed by the Grievance Review Committee. The following additional documentation submitted supports the MCP's efforts to correct this deficiency:

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				Monitoring/Oversight: - Audit Report, "Classification of Exempt Grievances/Compliance Review Results" (Q2 2022) 30 sampled exempt grievances were reviewed by the Compliance Department to determine if there was potential QOC concern and confirm the classification of the exempt grievances. In addition, the Medical Director reviewed the 30 exempt grievances and confirmed the cases were not QOC. There were no QOC grievances in the sample of cases misclassified as exempt. The overall passing score was 100%. **The Corrective Action Plan for Finding 4.1.1 is accepted.**
4.1.2 Quality of Care Grievance Process The Plan did not ensure that all QOC grievances were resolved by a Medical Director and that members received a clear and concise explanation of the Plan's decision. The Plan did not adhere to their policy and procedure.	A KHS Medical Director has been assigned to reviewing and identifying appropriate follow up actions required for QOC grievances. The following have been updated and/or newly created to fully define the process: All grievances received will be disseminated to the Grievance Committee members (including QI RN			The following documentation supports the MCP's efforts to correct this deficiency: **Policies and Procedures:** - Revised and Drafted P&P, "2.70-I: Potential Quality of Care Issues" (07/22) which is being revised to include a procedure that if a QI RN determines that a PQI exists, the grievance is referred to the designated Medical Director Physician for review and final determination of whether a PQI is present. - Revised and Drafted P&P, "5.01-I: KHS Member Grievance and Appeal System (Revised 03/04/22) was revised to remove, *"Once a grievance is identified as being a potential QOC concern, it is closed, with a resolution letter sent to the member informing them*

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
Recommendation: Revise and implement policies and procedures to ensure that all QOC grievances are resolved by a Medical Director and that members receive a clear and concise explanation of the Plan's decision.	and Medical Director) for validation of classification type. No grievance will be closed as "Exempt" without review by a QI RN and medical director. 1. Grievance Job Aid created 2. New Grievance Workflow created to clearly demonstrate Medical Director involvement 3. Content of member communication of grievance resolution template letters have been updated to include action taken. 4. Policy, 2.70-I Potential Quality of Care Issue (PQI) Policy 2-27-22 updated	1. Grievance Job Aid 2. KHS QOC Grievance Workflow 3. Revised Grievance Outcome Letters to Member 4. 2.70-I Potential Quality of Care Issue (PQI) Policy Draft 5. 5.01-I KHS Member	1. 03/03/2022 2. 03/21/2022 3. 03/21/2022 4. 03/21/2022 5. 03/21/2022	*that their complaint was sent to the QI Department for further review and the results of the review will be kept confidential*." The language added to the P&P: "*A resolution to the member's grievance is written from the Medical Director's recommendation and will include a clear and concise explanation of the Medical Director's decision*." **Monitoring/Tracking:** - Audit Tool, "Potential Quality of Care Issue (PQI) Audit Tool" (02/27/22) audits quarterly for the following: • Clear and concise recommendation to Medical Director made by reviewing RN, if sent to Medical Director for review. • Medical Director rationale for determination is clear and concise, if referred to Medical Director **Training:** - Meeting, Microsoft Team Meeting, "Grievance Process Update" (03/17/22) and attendance summary with names of participants. This meeting was to review which included the need for referral of QOC grievances to the Medical Director and ensuring clear and concise language is included in the resolution.

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	5. Policy 5.01-I has been updated to align with the new processes in 2.70-I Potential Quality of Care Issue (PQI) Policy 6. Compliance will conduct a monthly review of exempt grievances and report results to the Compliance Committee 7. Quality Department will conduct a quarterly audit of the QI review of the grievances to ensure appropriate QI processes followed	Grievance Process 6. Audit to begin in May 2022 & be reported in following Compliance Committee mtg 7. 2.70-I Draft; Potential Quality of Care Issue (PQI) Policy Attachment A Audit Tool Template	6. Audit to begin in May 2022 & be reported in following Compliance Committee mtg 7. Q3 2022	**Monitoring/Oversight:** - Audit Report, "Quality of Care Grievances/Compliance Review Results" (08/22) 30 sampled QOC grievances cases were reviewed and resolved by the Medical Director. Out of the 30 sampled cases reviewed, one case was not clear and concise due to delay in receipt of medical records. The overall passing score was 97%. **The Corrective Action Plan for Finding 4.1.2 is accepted.**
4.1.3 Classification of Grievances The Plan did not properly classify members'	1. Briefings scheduled for 3/16/2022 to update/remind MSRs on how to identify grievances and submit to Grievance Coordinators	1. 3/16/2022 Briefing Agenda and Power Point presentation	1. 03/16/2022	The following documentation supports the MCP's efforts to correct this finding:

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expressions of dissatisfaction as grievances. The Plan did not adhere to the Contract and its own policy. **Recommendation:** Revise and implement policies and procedures to ensure all member expressions of dissatisfaction are properly classified as grievances.	2. Grievance & Appeal reminders during monthly staff meetings 3. Quarterly G&A presentations to MS staff regarding ongoing or recently identified issues 4. Grievance Calls Closed by MSR Report received	2. 1/26/2022 Staff Meeting Agenda, Attendance Record, Summary of Grievance and Appeal Minutes from staff meeting; 2/23/2022 Staff Meeting Agenda, Attendance Record, Summary of Grievance and Appeal Minutes from staff meeting	2. 01/26/2022 3. 05/2022 (initial briefing 03/16/2022 noted above) 4. 02/09/2022	**Policies & Procedures:** - Revised and Drafted P&P, “5.01-I: KHS Member Grievance and Appeal System (Revised 03/04/22) was revised to include, “A member need not use the term “grievance” for a complaint to be captured as an expression of dissatisfaction and processed as a grievance by KHS. If a member expressly declines to file a grievance, the complaint must still be categorized as a grievance and not an inquiry.” **Monitoring/Oversight:** - Internal Audit, “Call Inquiry Review 2022”, (April – August 2022) the MCP conducts a quarterly review of member expressions of dissatisfaction to ensure they are properly classified as grievances. Out of 392 call inquiries performed, only three inquiry calls expressed dissatisfaction and those three calls were appropriately identified as a grievance. The MCP showed100% compliance for the period reviewed. **Training:** - Meeting, “Member Services Staff Meeting” (03/16/22) as evidence that a discussion took place regarding identifying a grievance and appeal. - PowerPoint Training, “Grievance and Appeals” (03/16/22) as evidence that the Member Services Representatives were briefed on, “An expression of dissatisfaction about any matter with a

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	and reviewed daily. Created 2/9/2022 5. Compliance will conduct a quarterly audit of call inquiries and report results to the Compliance Committee	4. Sample of Grievance Calls Closed by MSR Report 5. Compliance Audit Results (July)	5. Audit in July for Q2 2022 and reported in following Compliance Committee mtg	provider and/or KFHC for service received while eligible with the Plan. A complaint and a dissatisfaction is formally known as a Grievance. - Meeting, "Member Services Staff Meeting" (01/26/22) which discussed that all dissatisfactions are grievances and need to be call tracked to the Grievance Queue and left open for processing. - Meeting, "Member Services Staff Meeting" (02/23/22) which discussed that grievance calls coded/closed by MSR. Attendance reports was received to verify what participants attended the above meetings. **The Corrective Action Plan for finding 4.1.3 is accepted.**
5.1.1 Potential Inappropriate Care (PIC) Process The Plan did not monitor, evaluate, identify, and take effective action to address needed improvements in QOC delivered by providers. The Plan did not ensure that a	1. The 2.70-I Potential Quality of Care Issue (PQI) Policy has been updated to incorporate stronger actions by the QI RN to follow up on any referrals made to the medical director to ensure completion. Steps have also been strengthened to ensure appropriate follow up for CAPs issued have	1. 2.70-I Potential Quality of Care Issue (PQI) Policy Draft 2. 2.70-I Potential Quality of Care Issue (PQI) Policy Attachment	1. 03/21/2022	The following documentation supports the MCP's efforts to correct this finding: **Policies and Procedures:** Policy 2.70-I Potential Quality of Care Issues (2/22) has been revised and outlines processes to monitor, evaluate, and take effective action to address needed improvements in QOC. Procedures include continuous review of the quality of care provided to members, to ensure the level of care meets professionally recognized standards, and ensure all QOC problems are identified and corrected for all provider entities.

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QOC problems are identified and corrected for all provider entities. The Plan did not properly investigate and ensure corrective action of PICs before closure. **Recommendation**: Revise and implement Plan policy to ensure the PIC process includes identification, evaluation, monitoring and taking corrective action to address, resolve, and improve QOC issues delivered by providers.	occurred to support timely and effective PQI closure. Note: We have changed the name of PIC to PQI to align with the term used in our contract with DHCS. Language was also added to the PQI Policy Purpose to align with Tit. 28, § 1300.70 and Title 28, CCR, Section 1300.70 and 42 CFR 438.330. The added statements provide a stronger validation of KHS' Quality Improvement Program Structure assurance of appropriate monitoring and follow up with quality of care problems.	A Audit Tool Template 3. PIC Audit Q3 2021 4. PIC audit Q4 2021		**Implementation and Training:** The Plan has established a referral process - all PQI referrals are reviewed against professionally recognized evidence based standards of care and screened to determine if PQI issues exists. All grievances received are referred to QI grievance nurses for PQI evaluation. If additional information and/or medical records are needed, they are requested. Potential PQI is referred to the Medical Director/designee for final determination. If PQI is present, case is referred to QI Department to complete investigation. PQI referrals to CMO or designee are entered into the Medical Management System. A final determination of severity level and any follow up direction is documented. Severity level determines whether to track and trend (lower score) or impose corrective action. **Monitoring and Oversight:** Tracking and trending is performed to ensure identified QOC issues have been resolved or identify any continuing patterns of concerns or opportunities for improvement. Potential Inappropriate Care (PIC) Audits are conducted quarterly. Plan provided sample quarterly audits from 2021 - Q3 and Q4.

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				Corrective action process is outlined in the quarterly audits. Dependent upon score, the nurse reviewer will address areas of deficiency within 5 business days. **The Corrective Action Plan for Finding 5.1.1 is accepted.**
6. Administrative and Organizational Capacity				
6.2.1 Notification of Changes in Network Provider's Circumstances The Plan did not notify DHCS of changes in network provider's circumstances that affect the provider's eligibility to participate in the Medi-Cal MCP, including the termination of their provider agreement with the Plan. **Recommendation**: Approve and implement policy and procedure to ensure prompt notification to	1. Policy 14.04-P updated to include this requirement 2. Desktop level procedure created to clearly outline responsibilities for provider terminations and handoffs between departments. Multiple meetings held to review updated process with larger team, but deficiencies identified during audit occurred within the Compliance department. Meeting held 02/24/2022 to review updated processes and additional training will occur the week of 03/14/2022 for entire	1. 14.04 policy 2. Provider Terminations desktop level procedure	1. 03/10/2022 2. 03/01/2022	The following documentation supports the MCP's efforts to correct this finding: **Policies and Procedures**: - Updated P&P, "14.04-P: Prevention, Detection, and Reporting of Fraud, Waste, or Abuse" (03/04/22) which has been amended to include changes in network provider's circumstances. The MCP will provide prompt notification to DHCS when information is received about a change in a Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the Medi-Cal managed care program, including the termination of their Provider agreement with Contractor, in accordance with policy 4.39_P Provider Termination (page 4). - "Compliance Department Significant Provider Termination Process" (03/10/22) as evidence that the MCP has a desktop level procedure created to outline responsibilities for provider terminations and handoffs between departments. At least 60-days prior to the effective date of a voluntary contract termination, or immediately upon learning of the termination from the Network

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
DHCS of changes in network providers' circumstances.	Compliance team. 3. Moved from an 'email' system of communication to use of the KHS workflow to improve tracking and closure 4. 4.39-P Provider Termination Policy was previously updated in accordance with APL 21-003 but was not fully approved at the time of the audit. It has since been approved.	3. Screen prints from KHS workflow 4. 4.39-P approved policy	3. 02/28/2022 4. 03/07/2022	Provider/Subcontractor, provide DHCS with written notice of the termination, a Transition Plan, and Network Review Documents, as described in APL (6.2.1.1_14.04-P Prevention Detection and Reporting Fraud_2022.03, page 4). - Updated P&P, "4.39-P: Provider Termination" (03/07/22) which states the process of providing notice to all impacted members as described in APL 21-003. At least 60-days prior to the effective date of a voluntary provider network agreement termination, or immediately upon learning of the termination from the network provider, the Plan will provide DHCS with written notice of the termination (6.2.1.4_4.39-P Provider Termination 2021, Page 2). **Implementation**: - Screenshot, "KHS Workflow Item Screenshot for Provider Terminations" as evidence that the MCP moved from an email system of communication, to the use of the KHS workflow to improve tracking and closure (6.2.1.3_KHS Workflow Item Screenshot for Provider Terminations). **Monitoring:** - Updated P&P, "14.04-P: Prevention, Detection, and Reporting of Fraud, Waste, or Abuse" (03/04/22) which has been amended to include implementation on enhanced monitoring. The MCP will monitor relevant claims, claim lines, and encounter data and complete the initial review with thirty (30) days. The MCP will also provide weekly updates to the DHCS until a determination is made

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				as to whether an on-site visit is necessary. The MCP will also provide to the DHCS an outline of oversight activity KHS will conduct to ensure there is no further fraud, waste, or abuse (6.2.1.1_14.04-P Prevention Detection and Reporting Fraud_2022.03, Page 3). **The Corrective Action Plan for Finding 6.2.1 is accepted.**
6.2.2 Verification of Services Delivered The Plan did not have policies and procedures to verify the services that have been represented to have been delivered were received by members. **Recommendation**: Develop and implement policies and procedures to verify that services represented by network providers	1. Policy 14.04 – P has been updated to add verification of services delivered. 2. Letter created to send to members based on a sampling of claims at least quarterly. 3. Created log to track and report on responses to Compliance and/or FWA Committee based on responses.	1. 14.04-P 2. Verification of Services Letter 3. Verification of Services Log	1. 03/10/2022 2. Upon regulatory approval of letter (target to mail first letters in April)	The following documentation supports the MCP's efforts to correct this finding: **Policies and Procedures:** MCP updated P&Ps to address the gap that contributed to the deficiency. The MCP samples and surveys members to verify services were received. In cases where a member responds and advises they did not receive the service, then the MCP requests and reviews the member's medical record to ensure the service was or was not provided. - P&P, "14.04-P: Prevention, Detection, and Reporting of Fraud, Waste, or Abuse" (03/04/22) was revised to include requirement to verify that services represented by network providers were indeed received by members. (Page 4)

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were indeed received by members.				**Monitoring and Oversight:**
				
				The MCP developed monitoring procedures:
				- On a quarterly basis, KHS Compliance department will send letters to sampled member to verify services for which KHS has received claims. Minimum of 150 claims will be sampled per quarter.
				- The KHS Compliance Department will keep a record of responses and determine the appropriate course of action based on responses received (6.2.2.1_14.04-P Prevention Detection and Reporting Fraud_2022.03, Page 4).
				- Actions may include but are not limited to:
				  o Member Education
				  o Provider Education
				  o Additional research with provider (request medical records, etc.)
				  o Tracking and Trending
				  o FWA Investigation and/or Reporting
				- Results of the verification of services monitoring will be presented to the Compliance and/or Fraud, Waste, and Abuse Committee
				
				- “Example Outbound Verification of Services Letter” (08/26/22) which demonstrates that the MCP is mailing letters to members to verify that services billed by the provider were actually received by the member (6.2.2_Example_Outbound VOS letter).
				
				- “Sample Verification of Services Response from Member” (09/20/22) which demonstrates that the MCP received the

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				response from the member to confirm that the member received the services on the date of services listed on the letter (6.2.2_Sample VOS Response from member). - “Verification of Services Tracker,” (August 2022) which demonstrates that the MCP has a completed version of their tracker and is verifying that services represented by network providers were indeed received by members. - Additional oversight (01/20/23): MCP deployed a separate corporate initiative that utilizes a medical record review. The example of these efforts as provided by the Plan states: the Plan identifies the top five providers consistently billing a higher level of E & M code and requests medical records to support the claims submitted by the provider. The MCP conducts data mining to look for outliers in claims data, requests, and reviews medical records. **The Corrective Action Plan for Finding 6.2.2 is accepted.**
6.2.3 Notification to Program Integrity Unit of Suspended Providers The Plan did not adhere to its policy to ensure notification to the Medi-Cal	1. Policy 14.04-P updated to enhance language already included in this policy 2. Desktop level procedure created to clearly outline responsibilities for provider terminations and	1. 14.04-P 2. Provider Terminations desktop level procedure	1. 03/10/2022 2. 03/01/2022	The following documentation supports the MCP’s efforts to correct this finding: **Policies and Procedures:** - Updated P&P, “14.04-P: Prevention, Detection, and Reporting of Fraud, Waste, or Abuse” (03/04/22) which states that the MCP will notify the Medi-Cal Managed Care Program/Program Integrity Unit within ten (10) working days of removing a suspended, excluded,

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MCP/Program Integrity Unit within ten working days of removing a suspended, excluded, or terminated provider from its provider network. **Recommendation**: Implement policy and procedure to ensure the notification to the Medi-Cal MCP/Program Integrity Unit when a provider is excluded or suspended from participation in the Medicaid program.	handoffs between departments. Multiple meetings held to review updated process with larger team, but deficiencies identified during audit occurred within the Compliance department. Meeting held 02/24/2022 to review updated processes and additional training will occur the week of 03/14/2022 for entire Compliance team. 3. 4.39-P Provider Termination Policy was previously updated, but not approved at the time of the audit. It has since been approved.	3. 4.39-P	3. 03/07/2022	or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program. A removed, suspended, excluded, or terminated provider report will be sent to DHCS via Email (6.2.3.1_14.04-P Prevention Detection and Reporting Fraud_2022.03, Page 4). **Monitoring & Oversight:** - “KHS Ongoing Monitoring Report” (July 2022) as evidence that the MCP has an internal monitoring process to ensure notification to the Medi-Cal MCP/Program Integrity Unit within ten days of removing a suspended, excluded, or terminated provider from their provider network. The MCP’s credentialing team conducts a monthly review against the appropriate databases and provides a monthly report to the MCP’s Compliance Department (07-2022 _Ongoing_ Monitoring_ Rept_08-10-22). **Training:** - Meeting Invite, “Compliance’s Process for Provider Terminations” (02/24/22) as evidence that the MCP has held training within Compliance to review the requirements and new desktop guidance regarding provider terminations, a portion of which includes the notification to the Payment Integrity Unit (Provider Termination_Review_Meeting_20220224). - Updated Desktop Procedures, “Compliance Department Provider Termination Process” as evidence that the MCP’s Compliance

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				Department reviewed the updated Provider Termination Process during the training. **The Corrective Action Plan for Finding 6.2.3 is accepted.**
6.2.4 Fraud and Abuse Incident Investigation and Reporting to DHCS The Plan did not report all cases of suspected fraud and/or abuse and forward results of investigations to the DHCS within ten working days of initial awareness of suspected fraud and/or abuse activity. **Recommendation:** Implement the existing Plan policy to ensure adherence to the Contract and ensure that incidents	The original log referenced in Audit Report was not an internal FWA tracking & trending report. This report was being maintained related to potential overutilization of services. However, a clearly defined process was not in place to report suspected cases of FWA based on the over-utilization and/or prior authorization reviews to Compliance. We have established a formal process through which items identified through this log, or any other source, will be referred to Compliance for preliminary investigation and reporting within 10 working days of identification. The process includes:		Multiple meetings held, but actual meeting to revise final process scheduled for week of 03/14/2022 with Health Services Team	**Policies & Procedures:** - 14-04-P: The policy already included language regarding the requirement to report all cases & results of investigations of suspected fraud and/or abuse to DHCS within ten working days of initial awareness. The Plan revised to make the language to be more specific. (Page 2, section 1) - FWA – KHS Internal Referral Form: In conjunction with the revisions made to the Plan's policy, the Plan developed an internal referral process to ensure the proper documentation/details are included in its initial request to their compliance section to investigate suspected FWA. The Plan noted its internal form must be completed & submitted within 2 business days, to allow the Plan to meet the within 10-day requirement to report to DHCS. - FWA Preliminary Investigation Form: The Plan developed an internal formal FWA Investigation Report that allows the Plan to properly identify the issue, research conducted, reporting, & outcomes of any suspected FWA. This document along with the other internal processes developed, & the revised policy ensures that the Plan has a process in place of reporting in a timely manner. - FWA Process_202203: The workflow demonstrates the Plan's internal referral process to its compliance section. The workflow

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of suspected fraud and/or abuse is investigated and reported to DHCS within ten working days of awareness of such activity.	1. 14-04-P already contained language regarding this element, but it has been revised to be more specific. 2. KHS Internal FWA Referral Form developed 3. Workflow created for FWA process 4. Enhanced existing Compliance FWA log for tracking and reporting purposes 5. Created formal FWA Investigation Report to clearly document issue, research conducted, reporting, and outcomes. 6. Annual FWA training is being enhanced to include additional information for company-wide training.	1. 14-04-P 2. Internal Referral Form 3. FWA Workflow 4. Updated FWA tracking log 5. FWA Preliminary Investigation Form 6. Updated corporate-wide training	1. 03/09/2022 2. 03/09/2022 3. 03/09/2022 4. 02/28/2022 5. 02/28/2022 6. By June 2022	clearly outlines if FWA is suspected, the actions that may be taken including but not limited to corrective action plan. The workflow reiterates what the policy speaks to, along with the additional internal process forms speak to. **Implementation & Training:** - Example of 609 Submission Case B2022.37**:** The documentation submitted with this case example is the 609 form - showing the Plan has executed entirely on 06/22/2022 - sent via email to DHCS (07/01/2022) within the 10-day requirement, followed by DHCS acknowledgement that the complaint has been received. - The Plan states it has submitted numerous 609 forms to DHCS since implementation of its corrective action plan. **Monitoring & Oversight:** - 2022 FWA Log_07152022: The log demonstrates that the Plan is properly capturing all components of suspected FWA, monitoring, & tracking, inclusive of the outcome of identified/suspected FWA. **The Corrective Action Plan for Finding 6.2.4 is accepted.**

Submitted by: ***[Signature on File]*** **Date: 03/10/2022**
Title: **Director of Compliance & Regulatory Affairs**