KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Responding to Compliance Issues	**Policy #**	14.62-P
Policy Owner	Compliance	**Original Effective Date**	01/01/2024
Revision Effective Date	02/06/2025	**Approval Date**	07/10/2025
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

The purpose of this policy is to describe the process for reviewing and resolving potential compliance issues.

II. POLICY

KHS maintains effective systems for prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, and correction of such problems promptly and thoroughly to reduce the potential for recurrence, and ongoing compliance with the requirements under the DHCS Contract (42 CFR § 438.608(a)) and all state and federal requirements.

III. DEFINITIONS

TERMS	DEFINITIONS
Corrective Actions	Specific identifiable activities or undertakings which address Contract deficiencies or noncompliance.

IV. PROCEDURES

KHS maintains effective systems for prompt response to compliance issues as they are raised.

A. Identification of potential Compliance Issues

Potential compliance issues may be identified through multiple methods, including but not limited to:

1. Self-evaluation and/or Self-Reporting
2. Internal Monitoring and Auditing Activities

3. Delegation Oversight Activities

4. Regulatory Audits

5. Member Grievances, Appeals, or Provider Disputes

6. Ethics Hotline Reporting

7. The Fraud, Waste and Abuse (FWA) Program

8. Emails or verbal reports of concerns.

    a. Verbal reports will be well documented and reviewed with reporter to ensure accuracy of information captured.

B. Investigation of Potential Compliance Issues

Upon identification or receipt of report of non-compliance, the designated Compliance personnel will investigate potential compliance issues promptly and thoroughly, with oversight from the Director of Compliance and the Chief Compliance and Fraud Prevention Officer (CCFPO).

Compliance works collaboratively with all internal departments, Network Providers, and/or Subcontractors to effectively research and resolve any potential compliance issues.

1. Potential compliance issues are logged and tracked through to resolution on the KHS Compliance Issues Log.

2. Compliance will conduct a fair and impartial review of relevant facts.

3. Investigations may include but are not limited to:

    a. Interviews

        i. Interviews are conducted in a confidential manner, in a private setting.

        ii. Employee interviews include a reminder that the organization will not tolerate any form of retaliation for having participated in the investigation, and the interviewee should immediately report any perceived retaliation to the Director of Compliance or Chief Compliance and Fraud Prevention Officer.

        iii. Interviews of any potential wrong doers will include a reminder that KHS employees are required to cooperate with any investigations.

        iv. Interviewees wishing to remain anonymous will be advised the investigation will remain confidential to the extent possible.

    b. Review of any documentation provided by the reporter.

    c. Identification and review of the regulatory requirements associated with the potential

compliance issue.

d. Independent sample reviews or audits of a wider population to determine impacts as needed.

e. Requests for written response to the potential identified compliance issue.

f. Requests for additional documentation from the responsible department(s), network providers, or subcontractors.

g. Stakeholder meetings.

h. Engaging internal or external counsel, Human Resources, Executive Team, Compliance or Delegated Oversight Committees, or the Board of Directors, as needed.

i. Analysis of all compiled documentation against regulatory requirements.

4. The designated Compliance personnel will provide a complete summary of findings and recommendations based on the outcome of the investigation.

5. Case files are created for each potential compliance issue, in which the method of identification, documentation compiled during the investigation, meeting minutes and/or other communications, corrective action documentation and remediation, and final resolution documentation are stored on a secured drive.

6. The KHS Compliance Issues Log is reviewed during quarterly Compliance Committee meetings, maintaining confidentiality, and any required actions from the Committees will be incorporated into the investigations and/or corrective actions as appropriate.

7. Compliance issues related to delegated Subcontracts will also be reviewed, maintaining confidentiality, in the Delegation Oversight Subcommittee of the Compliance Committee.

C. Corrective Actions

KHS will develop and implement effective corrective actions for substantiated compliance issues identified to reduce the potential for recurrence and ensuring ongoing compliance with the requirements under the DHCS Contract (42 CFR § 438.608(a)) and all state and federal regulations.

1. All corrective actions will include a root cause analysis and tailored corrective actions to effectively resolve the compliance issue and prevent recurrence.

2. Corrective actions will vary depending on a variety of factors, which may include but are not limited to:

   a. the root cause

   b. the severity of non-compliance

c. the number of members impacted

d. the potential for member harm

e. financial impact

f. recurring or repeated non-compliance

g. failure to resolve the compliance issue timely

h. failure to adhere to subcontractor, downstream subcontractor, or provider contractual requirements.

i. Organizational risk

3. Corrective actions may be requested formally through a Corrective Action Plan (CAP), or informally, through other forms of communication and documentation.

   a. The type of corrective action will be recommended by the designated Compliance personnel and approved or updated by the Director of Compliance and Chief Compliance and Fraud Prevention Officer, based on the outcome of the investigation and impacts.

   b. The Director of Compliance or Chief Compliance and Fraud Prevention Officer will engage other parties as needed to finalize the type of corrective action.

   c. Regardless of the type of corrective action request utilized, all corrective actions will be thoroughly documented in the case file and summarized on the Compliance Log.

4. Corrective actions, as applicable, may include, but are not limited to the following:

   a. Member, provider, employee, or subcontractor re-training or education.

   b. Policy and procedure creation, updates, and implementation.

   c. Operational updates and implementation.

   d. System updates and implementation.

   e. Reporting updates and/or resubmissions as needed.

   f. Member and/or Provider outreach.

   g. Claims reprocessing, as needed.

   h. Personnel changes and/or disciplinary actions.

   i. Coordination of suspected criminal acts with appropriate law enforcement agencies, when appropriate.

j. Subcontractor contractual updates.

k. Additional sanctions.

l. Self-reporting to appropriate regulatory agencies.

m. Monitoring methodology to prevent recurrence.

5. Formal Corrective Action Plans will be reviewed and signed by the Chief Compliance Officer and the Executive Officer responsible for the area subject to the Corrective Action Plan.

    a. Corrective Action Plans involving Subcontractors or Network Providers will also require their signatures.

6. Corrective actions will be implemented to bring the identified compliance issue into full compliance within timeframes determined by KHS, and/or regulatory or contractual requirements, or KHS' regulatory agencies.

7. Failure to respond accurately, timely, and in compliance with corrective action requests or other requirements may lead to further action.

8. For contracted Network Providers, Subcontractors, and Downstream Subcontractors, KHS may impose sanctions, financial penalties, suspension of contracted functions, and/or contract termination as a result of the underlying non-compliant performance, or the failure to develop, submit, and meet the requirements of the corrective action request (*see 14.55 Delegation Oversight Policy*).

9. KHS will maintain records regarding the rectifying actions to close out the findings, including but not limited to committee meeting minutes detailing discussion of corrective action plans, description of outcomes, and evidence supporting the issue has been resolved, to demonstrate effective systems to address compliance concerns and implement effective corrective actions.

10. KHS will post Corrective Action Plans to our website when required.

11. KHS will ensure contractual provisions are in place through Subcontractor Agreements and Downstream Subcontractor Agreements, as relevant, to enforce corrective action plans when they are not met, such as financial sanctions, payment withholds, or liquidated damages (*see 14.61-P Delegation Policy).*

12. A risk assessment will be conducted on corrected compliance issues and incorporated into the Compliance Auditing and Monitoring Plan for follow-up monitoring and/or audits as needed to ensure ongoing compliance.

V. ATTACHMENTS

Attachment A:	Compliance Issues Log

VI. REFERENCES

Reference Type	Specific Reference
DHCS Contract (Specify Section)	1.3.1 Compliance Program
Other KHS Policies	14.55-P Delegation Oversight Policy
Other KHS Policies	14.61-P Delegation Policy
Other KHS Policies	14.63-P Compliance Monitoring and Auditing Policy

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revised	02/06/2025	The policy was revised by the Director of Compliance	J.M. Compliance
Revised	12/15/2024	Transferred to new Policy Template	J.M. Compliance
Revised	06/01/2023	New Policy created to further detail elements of the Compliance Program	J.M. Compliance

VIII. APPROVALS

Committees | Board (if applicable)	Date Reviewed	Date Approved
Choose an item.		
Choose an item.		

Regulatory Agencies (if applicable)	Date Reviewed	Date Approved
Department of Managed Health Care (DMHC)	Approved under Filing #20245234-5	02/06/2025
Department of Health Care Services (DHCS)	R.0243.2 submitted 06/14/2023	07/31/2023

Chief Executive Leadership Approval *		
Title	**Signature**	**Date Approved**
Chief Executive Officer		
Chief Medical Officer		
Chief Operating Officer		
Chief Financial Officer		
Chief Compliance and Fraud Prevention Officer		
Chief Health Equity Officer		
Chief Legal and Human Resources Officer		
Deputy Chief Information Officer		
*Signatures are kept on file for reference but will not be on the published copy		

KERN HEALTH SYSTEMS

Policy and Procedure Review

KHS Policy & Procedure: 14.62-P Responding Compliance Issues

Last approved version: N/A

Reason for Creation: New Policy created to further detail elements of the Compliance Program.

Director Approval		
Title	**Signature**	**Date Approved**
Jane MacAdam Director of Compliance & Regulatory Affairs		
Louis Iturriria Senior Director of Marketing & Member Engagement		
Melissa McGuire Senior Director of Delegation Oversight		
Robin Dow-Morales Senior Director of Claims		
Christine Pence Senior Director of Health Services		
Nate Scott Senior Director of Member Services		
Isabel Silva Senior Director of Wellness and Prevention		

Jacob Hall Senior Director of Contracting and Quality Performance		
Amisha Pannu Senior Director of Provider Network		
Bruce Wearda Director of Pharmacy		
Michelle Curioso Director of Population Health Management		
Magdee Hugais Director of Quality Improvement		
Andrea Hylton Director of Procurement and Facilities		
Amanda Gonzalez Director of Utilization Management		
Melinda Santiago Director of Behavioral Health		
Loni Hill-Pirtle Director of Enhanced Care Management		
Adriana Salinas Director of Community and Social Services		

Veronica Barker Controller		

Date posted to public drive: _____

Date posted to website ("P" policies only): _____