MEDICAL MUTUAL

Medicare Advantage Policy & Procedure

Incident Management & Communication

Policy No.	Responsible Area:	
MACP.PP.008	Medicare Compliance Oversight	
Date Approved:	**Approved by:**	**Date Reviewed/Revised:**
02/23/2021	Bae Hunt	Refer to revision notes

REFERENCE: Chapter 21 of the Medicare Managed Care Manual, including, but not limited to Sections 50.4 and 50.7; and the 2017 Program Audit Process Overview.

RELATED POLICIES AND PROCEDURES: Reported Incident, Investigations and CAP workflow; MACP.PP.009: Medicare Compliance Training; Medicare Compliance Committee Charter; MMO Code of Conduct; Policy No. 1988.001Records Retention Management; and Policy No. 2013.011 Breach Notification Requirements; Compliance Program Guide; CMS Reporting Subcommittee Charter.

SCOPE: The purpose of this policy and procedure is to outline Medical Mutual of Ohio's (MMO) process for receiving, investigating, and responding to suspected incidents of noncompliance, as well as demonstrate how and when incidents of noncompliance are communicated to the Compliance Committee, Governance Committee of the MMO Board of Directors, and/or CMS.

DEFINITIONS:

BOD – Board of Directors; MMO's governing body

CMS– Centers for Medicare and Medicaid Services; a regulatory agency, under the Department of Health and Human Services that regulates and oversees Medicare Advantage Organizations.

MMO– Medical Mutual of Ohio; the parent organization of the Medicare Advantage plan contracts

FDR– First Tier, Downstream or Related entity

POLICY: MMO has established multiple mechanisms to identify potential incidents of noncompliance. This includes but is not limited to proactive auditing and monitoring activity as well as user-friendly and accessible reporting mechanisms, including at least one anonymous mechanism, to receive, track, record, and respond to compliance questions and/or suspected incidents of noncompliance. These mechanisms, as well as the non-retaliation policy are published throughout the organization and to our FDRs in a myriad of ways.

MMO has established processes to ensure a prompt response to detected incidents of noncompliance. This includes a timely investigation of all reported incidents and execution of appropriate corrective action for all substantiated incidents of Medicare program noncompliance.

MMO maintains thorough documentation of all reported incidents, investigations, and corrective action plans for a minimum period of ten (10) years from the date the incident was identified by the organization.

Medicare Compliance provides routine reports to the Medicare Compliance Committee and the Governance Committee of the Board of Directors which includes information related to reported incidents and other key Medicare compliance metrics which may include disclosure of incidents of noncompliance. MMO considers all incidents deemed to be significant for self-reporting to CMS, as determined by the MMO CMS self-reporting subcommittee.

PROCEDURES:

Identification of Suspected Incidents of Noncompliance

Employee and FDRs have access to report suspected incidents of noncompliance and/or fraud, waste, or abuse (FWA) FWA via the following mechanisms:

- Email: MACompliance@medmutual.com
- Website: Compliance Connection (24/7 access and anonymous options available)
- Compliance Hotline: 1-800-762-8130 (24/7 access and anonymous)
- Medicare Compliance information SharePoint site: Click "Report a New Incident" button
- Direct Contact: Calling, emailing, or visiting any member of the Compliance department, including the Corporate Compliance Officer, Medicare Compliance Officer, and/or Director of Medicare Compliance
- FDR established reporting mechanism for FDR employees

- HIPAA Data Exposure Form

These mechanisms are published throughout MMO and FDR facilities in several ways, including but not limited to: posters; the corporate and compliance departments' intranet sites, special communications (e.g. screen savers or background) or forms; on compliance materials, in training/onboarding materials, and the MMO FDR Guide and website.

The corporate Code of Conduct and FDR Guide communicates the organization's expectation for all employees and FDRs to report any and all suspected incidents of noncompliance and FWA via one of the established mechanisms. Failure to report known issues related to noncompliance or FWA can result in disciplinary action, as outlined in the MMO Code of Conduct or FDR Guide, as applicable. Employees and FDRs are trained to report these types of incidents via the required compliance training and compliance policies and procedures.

Incidents of suspected noncompliance are defined as incidents that violate, or potentially violate, federal or state law, government funded program requirements or potentially harm enrollees. In addition, employees must report incidents of suspected fraud which includes incidents where intentional deception or misrepresentation that the individual knows to be false, to result in financial or personal gain; waste, which is defined as overutilization of services or other practices resulting in unnecessary costs to the Medicare program, i.e. misuse of resources or inefficiencies; and abuse which is generally incidents in which paid claims or services should not be paid by Medicare, i.e. rule bending (e.g. improper payment, payment for services that fail to meet recognized standards, or medically unnecessary).

Reporting exceptions:

- MMO operational areas monitor their Medicare functions routinely to ensure compliance; to identify, track and resolve isolated incidents of noncompliance as part of their routine operational processes. With these mechanisms in place, MMO Medicare operational areas are expected to ensure quick, effective remediation to resolve any isolated incidents of noncompliance on a routine basis. If the MMO Medicare operational area identifies reoccurring incidents or trends of noncompliance, systemic issues, or incidents posing beneficiary harm due to noncompliance, the operational area must report the incident to the Medicare Compliance department via one of the valid reporting mechanisms listed above in a timely manner.
- Some FDRs provide advance reporting of suspected incidents of noncompliance to all clients, including MMO, prior to validating individual client impact. In this case, the operational owner will initiate and track the investigation issues prior to reporting to Medicare Compliance. Once MMO has confirmed that the reported incident does impact MMO, the operational owner will immediately report the incident to Medicare Compliance and update the incident to reflect all investigative activity and/or related documentation.

MMO's corporate non-retaliation policy is published and available on the corporate intranet site and included as part of the required compliance training. Additionally, the FDR Guide which is published on the FDR hidden website communicates and enforces MMO's non-retaliation policy to FDRs. These policies formally demonstrate the organization's commitment to building and fostering a culture of compliance. No employee, FDR, or FDR employee shall be retaliated against for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, or audits, or supporting execution of necessary remedial action.

The reporting mechanisms are managed and overseen by one or more of the following departments: Corporate Compliance, Medicare Compliance, Financial Investigations, and/or Legal. These departments have established collaborative processes to ensure incidents are shared with the appropriate department and acknowledged timely. Corporate Compliance addresses reported incidents or potential violations of corporate policy; Legal addresses incidents related to potential HIPAA issues and/or federal or state regulations; Financial Investigations addresses reported incidents related to FWA; and Medicare Compliance manages response to incidents related to the Medicare program. Corporate Compliance forwards Medicare related issues received through the Compliance hotline to MA Compliance.

Investigations

Medicare Compliance oversees investigations of suspected incidents of noncompliance related to the Medicare program through the Incident Management process. Upon receipt of a reported incident, Medicare Compliance reviews the incident/allegation and identifies the appropriate Medicare Advantage operational owner ("MA operational owner") to perform the investigation. The investigation is assigned within 1 business day of receipt to the MA operational owner(s) who is responsible for the function(s) related to the reported incident/allegation according to the Medicare Personnel list on the Medicare Compliance SharePoint site. The MA operational owner is assigned to perform the investigation. The MA operational owner(s) is notified of their responsibility to complete the investigation through an automated email. The MA operational owner can delegate the investigation to other, capable personnel. However, the MA operational owner is accountable for ensuring a thorough, documented and timely investigation is completed. The MA operational owners are responsible for engaging other areas that may support resolution.

Once the MA operational owner receives notification of their responsibility to perform the investigation, the investigation must be initiated, and initiation documented, as quickly as

possible but no later than two (2) weeks from the date the issue was identified. Medicare Compliance monitors timely initiation of assigned investigations.

The purpose of the investigation is to substantiate or unsubstantiated the reported incident/allegation. The MA operational owner, or delegate, is responsible for performing appropriate and sufficient investigative activity to validate whether the incident/allegation occurred. The activity conducted as part of the investigation is documented on the Investigation Form (Appendix A). One (1) Investigation Form is completed for each reported incident. MA operational owners are expected to collaborate to capture any and all investigative activity required from multiple operational areas. As part of this process, the MA operational owner, or delegate, is required to perform a root cause analysis and perform a beneficiary impact analysis.

Once the investigation is complete, the completed Investigation Form is submitted to Medicare Compliance by the MA operational owner, or delegate(s). The investigation must be completed and submitted as soon as possible but no later than 30 days from the date the investigation was initiated, unless a justifiable extension is approved by Medicare Compliance. Medicare Compliance will review the investigation to identify: (1) whether the incident/allegation was substantiated or unsubstantiated; and (2) if substantiated, identify whether the incident violated any Medicare program requirement(s).

- If the reported incident was unsubstantiated: no corrective action plan (CAP) is required.
- If the reported incident was substantiated, with no violation of Medicare program requirement: no CAP is required from Compliance; MA operational owner is responsible for addressing identified operational issues.
- If the incident was substantiated and violated a Medicare program requirement: CAP is required

An automated email notification is sent to the MA operational owner(s) of the direction based on the methodology listed above.

All information related to investigations performed to address reported incidents, including the completed Investigation Form and beneficiary impact analysis, is housed and tracked on the Medicare Compliance Information SharePoint site. The MA operational owner is responsible for ensuring all incident related data and documentation is accurate and comprehensive.

HIPAA Investigations

For any actual or suspected HIPAA related incident that impacts a Medicare member, MA operational owners are required to complete the HIPAA Data Exposure Form.

Refer to Corporate Policy 2013.011 Breach Notification Requirements which outlines the process for HIPPA incident investigations and remediation activities.

Corrective Actions

Formal and documented CAPs are required by Medicare Compliance to outline and document action taken to address any and all substantiated issues of Medicare program noncompliance ("noncompliance"). This includes, but is not limited to, substantiated issues of non-compliance identified via investigations of reported incidents, internal auditing and/or monitoring activity, regulatory compliance actions, and/or regulatory monitoring, review, or audit results.

Each substantiated incident of noncompliance requires a completed CAP form (Appendix B). This form is completed by the MA operational owner and/or delegate(s), and captures the important data related to the remedial action. The MA operational owner(s) must develop, outline, and document actions to remediate the identified operational/systemic issues and negatively impacted beneficiaries based on the root cause analysis performed.

The completed CAP form is due to Medicare Compliance within ten (10) business days from the date the CAP was requested by Medicare Compliance, unless a justifiable extension is approved by Medicare Compliance in advance of the original CAP due date.

Upon receipt of the completed CAP form, Medicare Compliance reviews the initial CAP to verify it is complete and the CAP items appropriately address the issue, root cause, member impact, and include measures to prevent reoccurrence. CAP Review meetings are scheduled with the applicable operational owner, delegate(s), and other stakeholders for the purpose evaluating the initial Corrective Action Plans (CAPs) submitted for incidents that are created as a result of an internal or external audit or are deemed as significant; refer to, CMS Reporting Subcommittee Charter 2020112.MA. Compliance feedback is provided on the CAP form once the review is complete. The MA Compliance review and/or CAP Review meetings should occur as soon as possible after receipt of the initial CAP. The MA operational owner, or delegate(s), have five (5) business days from the date MA Compliance provided feedback to revise the CAP and provide signatures. All CAPs require Director level or above sign-off prior to final submission.

All information related to the CAP, including the completed CAP form, is housed and tracked on the Medicare Compliance Information SharePoint site in the incident specific library.

Generally, CAP completion and/or target completion dates should occur within thirty (30) days of the CAP submission date. With exception, some remediation may take longer to complete. If so, MA operational owner(s) are expected to provide short-term and long-term remediation steps. All exceptions are expected to be communicated to Medicare Compliance and documented.

Validation

MA operational owners, as assigned on the completed CAP form, are responsible for ensuring full and timely execution of all CAP items. Failure of a responsible party's cooperation to comply with

the assigned CAP items may result in disciplinary action.

Additionally, MA operational owners are responsible for validating effectiveness of CAPs via the appropriate oversight activity including but not limited to documenting timely execution of CAP items and/or conducting monitoring and/or auditing to test effectiveness of the remediation.

Validation should occur during the "clean period"; the period after all relevant CAP items have been completed. MA operational owners are responsible for documenting the completion of their validation on the Validation Form via SharePoint (Appendix C) and saving corresponding documentation in the incident specific folder. MA operational owners are expected to confirm the completion dates for each remediation item provided on the CAP and document validation activities (e.g. monitoring, testing, etc.) conducted which demonstrate effectiveness thereof. MA operational owners must complete validation as quickly as they are able to base on the defined clean period. Generally, validation completion should not exceed 120 calendar days from the date the final CAP was submitted to MA Compliance.

Medicare Compliance considers, as part of the Risk Assessment and Audit Work Plan processes, the need or opportunity to perform sample audits of completed CAPs to validate effectiveness of these CAPs.

Monitoring and Communication

Medicare Compliance monitors, via automatic and manual monitoring processes, all reported incidents to ensure timely response to all detected incidents, as well as timely investigations and CAP completions. Additionally, Medicare Compliance maintains a SharePoint site with a personalized view for assigned MA accountable owner(s) and delegate(s) to monitor their assigned incidents and corresponding activity. In addition, Medicare Compliance has implemented systems to notify MA accountable owners of assigned tasks and statuses of assigned tasks related to this process and reminder/overdue notices sent to ensure MA accountable owners are informed and to facilitate timely responses. These assigned tasks and notices are monitored by Medicare Compliance. The Medicare Compliance Oversight team provides weekly overdue incident reports to the Vice President (VP) of any area with overdue incidents. Additionally, all incidents with an overdue status are reported to the Medicare Operations/Compliance sub-committee on a bi-weekly basis.

Medicare Compliance offers and conducts routine meetings, as needed, with members of senior leadership to discuss identified compliance issues and/or topics related to existing incidents, investigations, and CAPs managed by their department.

MA accountable owners are encouraged to report, as a member or through their leadership who attends, to the Medicare Compliance Committee (the "Committee") any suspected or substantiated incidents of noncompliance they feel needs to be escalated to the Committee for any reason,

including solicitation of feedback and/or to facilitate resolution. Additionally, on a routine basis, Medicare Compliance reports the following to the Committee: (1) finalized auditing and monitoring activity conducted by the Medicare Advantage Audit team or CMS; (2) any and all substantiated incidents of noncompliance with substantial or significant impact to the organization and/or enrollees; (3) any and all CMS compliance or enforcement actions.

On a quarterly basis, Medicare Compliance reports the following to the Governance Committee of the MMO Board of Directors (BOD): (1) finalized auditing and monitoring activity conducted by the Medicare Advantage Audit team or CMS; (2) any and all substantiated incidents of noncompliance with substantial or significant impact to the organization and/or enrollees; (3) any and all CMS compliance or enforcement actions.

The Medicare Advantage Audit Team will conduct a review to validate proper and timely execution of corrective action plans and validation activity on a risk basis.

MA accountable owners are responsible for maintaining supporting documentation for all phases of the process (i.e. incident identification/examples, investigation activity, corrective action plan execution, and validation activity) in the incident specific library to demonstrate execution and maintain incident related documentation in a centralized location.

Accountable owners may submit a request for extension of any deadline as needed and as early in the process as possible. The request for extension must be submitted prior to the due date. Requests for an extension must to MACompliance@medmutual.com. The written request for extension must include a new target due date and a justification for why the extension should be granted. MA Compliance will consider these requests on a case-by-case basis.

Any and all substantial or significant incidents of noncompliance, are referred to the subcommittee for consideration to report to the organization's CMS Account Manager as soon as possible.

APPROVED BY

Megan Grifa, Medicare Compliance Officer *02/23/2021*

Name, Title Date

Record of Review and Revisions

Section	Review/Revision Notes
All	New document
Identification of Suspected Incidents of Noncompliance	Added language to define when the operational area must self-report

9/25/2017	All	Resolve grammar/spelling errors throughout. Added language to explain processes for receiving reported incidents from Sales Compliance, Phcy (ESI Alerts) and Enrollment (Wipro). Changed CAP due date from 3 days to 10 days.
6/20/2018	All	Added the word "oversight" to the Responsible Area section to specify that this P&P belongs to Medicare Compliance Oversight. Removed section allowing Sales Compliance to only report substantiated issues. Removed language requiring completed investigation form to be submitted upon reporting ESI/Wipro issues. Added language to capture CC reporting of active and overdue incidents. Added content regarding HIPAA investigations. Added Appendix A and B
7/5/2018	Monitoring and Communication, Validation	Revised section to explain that the subcommittee reviews all substantial/significant issues to determine whether they are reported to the CMS AM. Added reference to the Validation Form and Appendix C.
8/28/2019	All	Added new MA Compliance review timeframes. Added screenshots of the new Investigation and CAP forms. Added If so, MA accountable owner(s) are expected to provide short-term and long-term remediation steps. All exceptions are expected to be communicated to Medicare Compliance and documented.

03/13/2020	Validation	Added content to Validation section: 1. include CAP validation deadline of 120 calendar days from the date the final CAP is received. Added content to Monitoring and Communication section: 1. Removed references to the incident reporting on the quarterly compliance dashboard and replace with "recently substantiated incidents initiated via reporting" 2. Added statement requiring AO to maintain supporting documentation in the incident library 3. Added reference to bi-weekly sub-committee overdue reporting 4. MAA audits of incidents will be performed on a risk basis 5. Included extension request directives
02/19/2021	Validation Language	Added the following content: MA accountable owners must complete validation as quickly as they are able based on the defined clean period. Validation completion should not exceed 120 calendar days from the date the final CAP was submitted to MA Compliance
	CAP Review Meetings	Added the following content: CAP Review meetings are scheduled with all accountable owners/stakeholders for evaluating the initial Corrective Action Plans (CAPs) submitted for incidents that are created as a result of an internal or external audit or are deemed as significant. MA Compliance feedback is provided on the CAP form once the review is complete. The MA Compliance review and/or CAP Review meetings should occur as soon as possible after receipt of the initial CAP. All CAPs require Director level or above sign-off prior to final submission.

Appendix A

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Medicare Advantage Investigation Form

Incident #:	[Incident #]
Investigator:	[Owners]
Title:	[Title]
Date Incident Initiated:	[Date Incident Initiated]
Incident Description:	[Incident Description]

Step 1: *The information above is auto populated based on the Reported Incident.*

Please enter all activity conducted to investigate the allegation in the fields below. The investigation must be completed within 30 days (max 90 days).

DATE:	TIME:	ACTIVITY:

To add an additional row, double click "Add a Row". You may add as many rows as needed.

Save | Close & Save Form

Step 2: *Please enter the Investigation Summary - Conclusion in the required fields below.*

Related Regulation (MMCM, PDBM and/or CFR citation):			
The investigation determined that:			**Is this a PDE, DIR or P2P?**
[Enter Investigation Summary – Conclusion]			[Select from Dropdown]
Date Incident Occurred:	**Number of Beneficiaries Impacted:**	**Avg. Financial Impact to Affected Mbr(s) or Enter N/A:**	**Systemic Issue (Y/N):**
[Enter Date Incident Occurred]	[Enter a Number – No Commas]	[Enter Avg Financial Impact]	[Select from Dropdown]

**If Beneficiary Impact is greater than 0, you must submit a report of the beneficiaries impacted and all applicable information. Save the report in your Incident library folder.*

Date Investigation Completed:	Whom Completed Investigation:	Results:
[Date Investigation Completed]		[Select from Dropdown]

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Medicare Advantage Investigation Form

Step 3: Please enter the Root Cause Analysis & Methodology in the fields below.

Root Cause(s): Provide the root cause that attributed to the overall issue. Root causes are underlying faulty processes or system issues that lead to the incident. Often there are several root causes for an event.
Based on the above findings, the investigator determined that the root cause was:
[Enter the Root Cause]
Methodology Used to Determine Root Cause: Provide the approach used to establish why the issue occurred; explain how the root cause was determined.
The investigator used the following methods to determine root cause (i.e., interviews, report analysis, staff shadowing, policy review):
[Enter Methodology Used to Determine Root Cause]
Methodology Used to Determine Full Scope of Impacted Beneficiaries: Provide the approach to identify other beneficiaries affected by the issue; explain how all other impacted beneficiaries will be identified.
The investigator used the following methods to identify the affected beneficiaries:
[Enter Methodology Used to Determine Full Scope of Impacted Beneficiaries]

Beneficiary Impact Provided?	Select from Dropdown

Step 4: OPTIONAL: Enter the date the manager reviewed and approved the content on this form. This is for use based on our policy for submitting this form to Compliance.

Manager Approval Date: [Manager Approval Date]	**Name of Management Approver:**

Once the fields above are complete, click the Submit button to send the completed Investigation Form to Medicare Compliance.

Click to Spell Check

Click the Submit button for final submission. Changes cannot be made after you click submit!

Submit

Appendix B

Corrective Action Plan (CAP) Form

Date Incident Reported to Compliance:	[Date Incident Reported to Compliance]
Date CAP Requested by Compliance:	[Date Cap Requested by Compliance]

Finding Provide description of **WHAT** happened concise				
Date Incident Occurred:	**Incident #:** Retrieve from Compliance Reported Incidents & Investigation Log	**Investigation Summary – Conclusion:**	**Internal Owner:** List business owner(s) responsible for function	**Responsible FDR:** List FDR(s) responsible for function
[Date Incident Occurred]	[Incident #]	[Investigation Summary - Conclusion]	[Owners]	[FDR Responsible]

Impact Analysis		
Root Cause(s): Briefly describe WHY it happened (Ask yourself WHY multiple times to identify the TRUE root cause)		
[Root Cause]		
Number of Impacted Beneficiaries*:	**Avg. Financial Impact to Affected Mbr(s) or Enter N/A:**	**Systemic Issue (Y/N):**
[Number of Beneficiaries Impacted]	[Avg Financial Impact]	[Systemic Issue?]

Step 1: The information above is auto populated based on the Reported Incident.
Step 2: If applicable, complete the necessary fields in the Reporting section below:

Reporting Capture the dates the operational owner reported the incident for the Medicare Compliance Committee and/or Senior Management			
Date Reported to Senior Management within the Dept or Enter N/A:	[Enter Date]	**Date Reported to the Medicare Compliance Committee or Enter N/A:**	[Enter Date]

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Corrective Action Plan (CAP) Form

Step 3: Complete Systemic/Operational and Beneficiary Remediation CAP sections below:

Note: There is a limit of 5 lines for each corrective action plan, per category. If more lines are needed, email MACompliance@medmutual.com

Systemic/Operational Remediation: Corrective Action Plan (CAP) CAP should include all action(s) taken to remediate (1) systematic/operational issues, (2) actions taken to prevent reoccurrence					
Activity Type: (i.e., Process Update, Reporting, Monitoring, Training, System Update or Change, New Policy/Policy Change, Discipline/Coaching, Other)	**Corrective Action Taken:**	**Responsible Person and Department:**	**Date Initiated:**	**Target Completion Date:**	**Date Completed:**

Beneficiary Remediation: Corrective Action Plan (CAP) CAP should include all action(s) taken to remediate (1) negatively impacted beneficiaries and (2) actions taken to prevent reoccurrence					
Activity Type: (i.e., Outreach, Adjustment, Other)	**Corrective Action Taken:**	**Responsible Person and Department:**	**Date Initiated:**	**Target Completion Date:**	**Date Completed:**

Corrective Action Plan (CAP) Form

Beneficiary Remediation: Corrective Action Plan (CAP) CAP should include all action(s) taken to remediate (1) negatively impacted beneficiaries and (2) actions taken to prevent reoccurrence					
Activity Type: (i.e., Outreach, Adjustment, Other)	**Corrective Action Taken:**	**Responsible Person and Department:**	**Date Initiated:**	**Target Completion Date:**	**Date Completed:**

Click to Spell Check

Save | Save & Close Form | Initial Submit

Click the Initial Submit button to submit your initial CAP to Compliance for review. ***Do not click Final Submit before Initial Submit.***

CAP Initial Submit Date:	[DateCap Initially Submitted]

This field is auto populated. You do not need to select a date.

********** For Internal Compliance Use Only **********

CAP Review Comments:	**Date Reported to the BOD or Enter N/A:**	**Date CAP Incident Self-reported to CMS or Enter N/A:**	**Whom was the incident reported to at CMS or Enter N/A:**
[Comments]	[Enter Date]	[Enter Date]	[Enter Whom Reported]

Prior Incident Date(s), Description and/or CAP# or Enter N/A:	[Enter Date]
Compliance Reviewer Signature:	[Enter Name]

Compliance Submit

Compliance Review Date:	[Date Cap Reviewed by Compliance]

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Corrective Action Plan (CAP) Form

Step 4: Make all necessary changes, obtain signatures and submit final version below:

Operational Owners Approval Add any additional comments and/or responses to Compliance Review			
Additional Comments:			
Signature of Submitter:		**Date:**	
Operational Approval Signature:		**Approval Date:**	

Final CAP Submission Date:	[Date Final Cap Submitted]

This field is auto populated. You do not need to select a date.

Final Step 1: **Click to Finalize**

*Must click to finalize CAP form **before** Final Submit.*

Final Step 2: **Final Submit**

*Must click "Click to Finalize" button first! Changes **cannot** be made after clicking Final Submit. This submission is **final**.*

Appendix C

CAP Validation Form

Full Remediation Attained?	Date CAP Validation Completed:
[Select from Dropdown]	[Enter Date]

Comments :
[Validation Comments]

Save | Save & Close Form | Submit