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Department of Health Care Services



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GOVERNOR

Bradley Gilbert M.D., CEO
Inland Empire Health Plan
10801 Sixth Street, Suite #120 P.O. Box 18
Rancho Cucamonga, CA 91730

July 25, 2016

RE: Department of Health Care Services Medical Audit

Dear Dr. Gilbert:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Inland Empire Health Plan, a Managed Care Plan (MCP), from October 5, 2015 through October 16, 2015. The survey covered the period of October 1, 2014 through September 30, 2015.

On July 21, 2016, the MCP provided DHCS with additional information regarding the Corrective Action Plan (CAP) in response to the report originally issued on February 29, 2016.

All items have been reviewed and found to be in compliance. The CAP is hereby closed. The enclosed report will serve as DHCS' final response to the MCP's CAP.

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

If you have any questions, feel free to contact Jeanette Fong, Chief, Compliance Unit, at (916) 449-5096 or CAPMonitoring@dhcs.ca.gov.

Sincerely,

Jeanette Fong, Chief
Compliance Unit

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Enclosures: Attachment A CAP Response Form

cc: OZ Kamara, Contract Manager
Department of Health Care Services
Medi-Cal Managed Care Division
P.O. Box 997413, MS 4408
Sacramento, CA 95899-7413

**ATTACHMENT A
Corrective Action Plan Response Form**



Plan Name: IEHP

Audit Type: DHCS Medical Audit

Review Period: October 1, 2014 through September 30, 2015

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 letter. MCPs are required to submit the CAP via email in word format which will reduce turnaround time for DHCS to complete its review.

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. For deficiencies that require long term corrective action or a period of time longer than 30 days to remedy or operationalize, the MCP must demonstrate it has taken remedial action and is making progress toward achieving an acceptable level of compliance. The MCP will be required to include the date when full compliance is expected to be achieved.

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.

CORRECTIVE ACTION PLAN FORMAT

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
<p>2.4.1 TIMELY COMPLETION OF INITIAL HEALTH ASSESSMENT (IHA) Although the Plan has policies and procedures that are consistent with the contract, the verification study revealed the IHAs</p>	<p>Remediation Activity: IEHP has implemented the following remediation activities:</p> <ol style="list-style-type: none"> IEHP's Healthcare Informatics (HCI) department developed new criteria for 2016 reporting that incorporates revised CPT and HCPCS codes. HCI implemented 	<p>Policy & Procedures: N/A</p> <p>Training: 1. On December 16, 2015, IEHP's Nurse Educators received training on the IPA</p>	<p>12/16/15: IEHP Nurse Educators received training on the new P4P IHA measure.</p> <p>IEHP's Governing Board approved the IHA</p>	<p>05/10/16 – IEHP submitted:</p> <p>-“IHA 120 Day Quarterly Report – Medi-Cal Members” (Attachment A) for Q4 2015 which shows that the Plan is tracking IHA completion rates for directly contracted providers and its medical groups.</p> <p>-A screenshot of how providers login to view a</p>

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<p>were not completed within the 120 days following the date of enrollment in five medical records.</p> <p>Recommendation: The Plan shall implement monitoring procedures to properly ensure that new Members receive IHAs within 120 calendar days of enrollment.</p>	<p>this change as of January 1, 2016.</p> <p>a. IHA Reports are generated using the new criteria and reported quarterly to the Quality Improvement Subcommittee. Please see <i>Deficiency 2.4.1 – Attachment A - QuarterlyReport_2015-Q4</i>.</p> <p>2. IEHP implemented IHA Pay for Performance (P4P) Program. As part of the IHA P4P Program, Providers must complete all components of the IHA in order to receive a monetary incentive. This program was approved by IEHP’s Governing Board in December 2015.</p> <p>3. To support the IHA P4P Program, monthly Member rosters are available for both PCPs and IPAs, enabling them to proactively outreach to Members in need of an IHA.</p> <p>4. The Nurse Educator’s Provider Training Manual was updated on February 9, 2016 to include additional instructions on how Providers can identify new Members and schedule appointments to subsequent activities for IHA completion. Please see <i>Deficiency 2.4.1 – Attachment C – Steps to View Rosters Online</i></p> <p>5. During the face-to-face visit,</p>	<p>P4P measure so they can incorporate updates into the Provider Education training. Please see <i>Deficiency 2.4.1 – Attachment B – IHA Workgroup Calendar Invite</i>.</p> <p>2. IEHP Nurse Educators shall facilitate IHA training to all Providers during routine education visits conducted at the Provider’s offices.</p>	<p>P4P Program along with the new IHA P4P measure in December 2015.</p>	<p>list of members that require IHA completion. “Steps to View Rosters Online” (Attachment C).</p> <p>-Meeting minutes and agendas for the “Initial Health Assessment Workgroup” (10/02/15, 12/16/15, 02/17/16) as evidence that IHA issues are being discussed (Attachments E, F, G).</p> <p>-A power point description of the Plan’s P4P program, “Maximizing the NEW IEHP Global Quality P4P Program” (2016) which includes incentives for IHA completion (slide 4). (Attachment H).</p> <p>-“Quality Improvement Subcommittee” meeting minutes (11/17/15) which indicate the QIS is reviewing IHA completion data.</p> <p>-“Initial Health Assessment (IHA) Action Plan” which includes a description of various efforts the Plan has implemented to boost IHA compliance (e.g., P4P program, updated nurse educator training, provider education, etc.). (Attachment D)</p> <p>06/17/16 – IEHP submitted the following additional documentation:</p> <p>-Three samples of the “PCP Global Quality P4P Program – 2016 Interim Report” as evidence that IHA completion have been incorporated in the P4P program. (Attachments D3, D4, I).</p> <p>-Documentation from the Plan stating:</p> <p>“The methodology for developing an IHA</p>

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	<p>the IEHP Nurse Educator provides education to the Provider with the following IHA requirements. Please see <i>Deficiency 2.4.1 – Attachment D – Initial Health Assessments</i></p> <ul style="list-style-type: none"> a. The Nurse Educator shall educate practitioners to take advantage of sick visits and any other visits to complete components of the IHA. b. The Nurse Educator shall educate the Provider that an IHA can be completed over multiple visits in case the Provider does not have openings for one long visit during the first 120 days. c. The Nurse Educator shall ensure Providers receive educational materials regarding IHA requirements any time an IEHP Team Member visits the Provider's office. Educational materials shall be provided through standard Provider training. <p>Process Change:</p> <ul style="list-style-type: none"> 1. HCI shall generate IHA reports using revised methodology. Report submitted to the Quality 			<p>validation report has been tested, finalized and implemented on March 31, 2016. The IHA validation report will be used to compare the IHA rates calculated from the Medical Record Review audits and electronic report using HEDIS and CPT codes. The IHA validation report shall be available and presented to the QI Subcommittee scheduled for July 19, 2016.”</p> <p>This finding is closed.</p>

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	<p>Improvement Subcommittee March 15, 2016.</p> <ol style="list-style-type: none"> 2. Implemented 2016 IHA P4P Program for PCPs and IPAs. 3. Nurse Educators shall educate Providers on the IHA P4P measure during on-site visits. 			
<p>2.4.2 COMPREHENSIVE INITIAL HEALTH ASSESSMENT</p> <p>The verification study revealed that 19 medical records did not include all the required components of a comprehensive IHA.</p> <p>Recommendation:</p> <p>The Plan shall implement monitoring procedures to properly ensure that new Members receive comprehensive IHAs.</p>	<p>Remediation Activity:</p> <p>IEHP has implemented the following remediation activities:</p> <ol style="list-style-type: none"> 1. IEHP's Healthcare Informatics (HCI) department developed new criteria for 2016 reporting that incorporates revised CPT and HCPCS codes. HCI implemented this change as of January 1, 2016. <ol style="list-style-type: none"> a. IHA Reports are generated using the new criteria and reported quarterly to the Quality Improvement Subcommittee. Please see <i>Deficiency 2.4.2 – Attachment A - QuarterlyReport_2015-Q4</i>. 2. IEHP implemented IHA Pay for Performance (P4P) Program. As part of the IHA P4P Program, Providers must complete all components of the IHA in order to receive a monetary incentive. This program was approved by IEHP's Governing Board in December 2015. 3. To support the IHA P4P Program, 	<p>Policy & Procedures:</p> <p>N/A</p> <p>Training:</p> <ol style="list-style-type: none"> 1. On December 16, 2015, IEHP's Nurse Educators received training on the IPA P4P measure so they can incorporate updates into the Provider Education training. Please see <i>Deficiency 2.4.2 – Attachment B – IHA Workgroup Calendar Invite</i>. 2. IEHP Nurse Educators shall facilitate IHA training to all Providers during routine education visits conducted at the Provider's offices. 	<p>12/16/15: IEHP Nurse Educators received training on the new P4P IHA measure.</p> <p>IEHP's Governing Board approved the IHA P4P Program along with the new IHA P4P measure in December 2015.</p>	<p>5/10/16 – IEHP submitted:</p> <p>-The "Initial Health Assessments" grid as evidence that the Plan Nurse Educators inform providers on the required components of the completed IHA (H&P and IHEBA).</p> <p>06/17/16 – IEHP submitted the following additional documentation:</p> <p>-Three samples of IHAs that include all required components including the history & physical examination and Individual Health Education behavioral Assessment (IHEBA).</p> <p>This finding is closed.</p>

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	<p>monthly Member rosters are available for both PCPs and IPAs, enabling them to proactively outreach to Members in need of an IHA.</p> <p>4. The Nurse Educator's Provider Training Manual was updated on February 9, 2016 to include additional instructions on how Providers can identify new Members and schedule appointments to subsequent activities for IHA completion. Please see <i>Deficiency 2.4.2 – Attachment C – Steps to View Rosters Online</i></p> <p>5. During the face-to-face visit, the IEHP Nurse Educator provides education to the Provider with the following IHA requirements. Please see <i>Deficiency 2.4.2 – Attachment D – Initial Health Assessments</i></p> <p>a. The Nurse Educator shall educate practitioners to take advantage of sick visits and any other visits to complete components of the IHA.</p> <p>b. The Nurse Educator shall educate the Provider that an IHA can be completed over multiple visits in case the Provider does not have openings for one long visit</p>			

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	<p>during the first 120 days.</p> <p>c. The Nurse Educator shall ensure Providers receive educational materials regarding IHA requirements any time an IEHP Team Member visits the Provider's office. Educational materials shall be provided through standard Provider training.</p> <p>Process Change:</p> <ol style="list-style-type: none"> 1. HCI shall generate IHA reports using revised methodology. Report submitted to the Quality Improvement Subcommittee March 15, 2016. 2. Implemented 2016 IHA P4P Program for PCPs and IPAs. 3. Nurse Educators shall educate Providers on the IHA P4P measure during on-site visits. 			
3. Access and Availability of Care				
<p>3.5.1 TIMELY REIMBURSEMENT OF COMPLETE CLAIMS</p> <p>The verification study showed the Plan did not reimburse six Emergency Room (ER) claims and three Family Planning (FP) claims within 45 working</p>	<p>Remediation Activity:</p> <p>IEHP has implemented the following remediation activities:</p> <ol style="list-style-type: none"> 1. IEHP Claims department modified its timeliness alert notification tool which is indicated on the claim daily report to identify claims aging within 14 days of the 45 working day limit. This action shall allow 	<p>Policy & Procedures:</p> <p>N/A</p> <p>Training:</p> <p>Re-Training shall be conducted by May 13, 2016. Please see <i>Deficiency 3.5.1 –</i></p>	<p>Re-training on the usage of its inventory monitoring tool is scheduled on May 13, 2016 for completion.</p>	<p>05/10/16 – IEHP submitted:</p> <p>-An email as evidence that training was scheduled for 05/13/16. (Attachment A)</p> <p>-“Claims Compliance Audit Findings Analysis – Claims Processed” (Q1 2016) which demonstrates the Plan is monitoring timely processing of claims with reported compliance</p>

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<p>days after the date of receipt.</p> <p>Recommendation: The Plan shall ensure complete claims are reimbursed within 45 days of receipt.</p>	<p>IEHP Claims Team Members to review any claims approaching timeliness limits and process accordingly.</p> <p>2. IEHP Claim Processors shall receive re-training on the usage of its inventory monitoring tool to include:</p> <ul style="list-style-type: none"> a. Re-enforcement of timeliness standards b. Identification of untimely claims assigned to other Claim Processors that require escalation. <p>3. IEHP Claims department recalibrated its automated claim processing system, Diamond, to process claims by oldest receipt date. This action shall ensure aged paid claims are completed timely.</p> <p>4. IEHP Claims Supervisors shall add timeliness of claims handling results to all Claim Processors performance reviews.</p> <p>Quality Assurance: IEHP currently exceeds the regulatory requirements with over 99% of claims paid and denied within 45 days of receipt. Statistical information was validated to support timely reimbursement of complete claims through the following manner:</p> <p>1. Daily Inventory Monitoring: All</p>	<p><i>Attachment A – Training Calendar Appointment</i></p>		<p>rates of 99.98%. (Attachments B)</p> <p>05/25/16 – IEHP submitted the following additional documentation:</p> <p>-A sample of a daily inventory aging report, “Claims Inventory Aging” (05/18/16) which shows the number of open and pended claims. (Attachment C)</p> <p>-The Plan submitted a second “Claims Compliance Audit Findings Analysis – Claims Processed” (Q2 2016) which demonstrates the Plan continues to monitor timely processing of claims with reported compliance rates of 99.98%.</p> <p>This finding is closed.</p>

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	<p>Claim Processing staff is responsible for monitoring timeliness of unfinalized claim activity. Claim Processors and the Claim Supervisor review activity through the use of an inventory tracking tool that enables identification of claim age, status, and assigned users. Any claims approaching thirty-one (31) days are escalated for priority handling</p> <p>2. Month End Reporting: The IEHP Claims department compiles finalized claim results including performance and compliance measures for all DHCS and DMHC timeliness requirements. Please see <i>Deficiency 3.5.1 – Attachment B – Claims Processed Report</i>.</p>			
<p>3.5.2 TIMELY FORWARDING OF CLAIMS TO APPROPRIATE PROVIDERS</p> <p>The verification study showed the Plan did not forward five misdirected claims to the appropriate capitated providers within 10 working days of receipt.</p> <p><u>Recommendation:</u> The Plan shall ensure that misdirected claims are forwarded to the appropriate providers</p>	<p>Remediation Activity: IEHP has implemented the following remediation activities:</p> <ol style="list-style-type: none"> IEHP Claims department shall review and strengthen the claims processing system, Diamond, process to automatically identify IPA responsible claims as follows: <ol style="list-style-type: none"> Conduct root cause analysis when IPA responsible claims fail timeliness requirement. Perform any system configuration as needed. Address training needs. Conduct re-training to all Claims Team Members on proper 	<p>Policy & Procedures: N/A</p> <p>Training: Re-Training shall be conducted by May 13, 2016. <i>Please see Deficiency 3.5.2 – Attachment A – Training Calendar Appointment</i></p>	<p>Re-training on the usage of its inventory monitoring tool is scheduled on May 13, 2016 for completion.</p>	<p>5/10/16 – IEHP submitted:</p> <ul style="list-style-type: none"> -An email as evidence that training was scheduled for 05/13/16. (Attachment A) -A document titled “Claims Compliance Audit Findings Analysis – Misdirected Claims” (Q1 2016) (Attachment B) as evidence that the Plan is forwarding misdirected claims within 10 working days (14 calendar days). This report shows claims compliance shows the average rate of compliance to process misdirected claims is about 98%. <p>5/25/16 - IEHP submitted the following additional documentation:</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
<p>within 10 working days of receipt.</p>	<p>detection and handling of IPA claims.</p> <p>3. Develop safeguards to ensure that IPA responsible claims are manually printed daily and timely on the day after adjudication.</p> <p>a. Claims Administrative Assistant (AA) shall be part of the process to prevent untimely forwarding of claims. Also, the Claims AA shall re-generate IPA responsible claims in the event the printing job failed.</p> <p>b. Claims Technician shall act as a secondary coverage when the Claims AA cannot assume printing responsibilities.</p> <p>Quality Assurance: Claim Supervisors shall review the results daily frequently to detect deficiencies and undertake remediation. Statistical information was confirmed through monthly reporting to validate 99% timely forwarding of claims to appropriate providers. Please see <i>Deficiency 3.5.2 – Attachment B – Misdirect Report</i>.</p> <p>The Plan's May 25, 2016 follow-up response.</p> <p>Background:</p>			<p>-A flow chart titled "Timely Forwarding of Claim to Appropriate Providers" (Attachment C) dated 5/20/216, which outlines the MCP's process for forwarding misdirected claims to the IPA.</p> <p>6/9/16 - IEHP submitted following additional documentation:</p> <p>-The "IEHP Misdirected Claims Forwarding Grid for Plan" (Attachment D) which is an audit tool that the MCP developed for its monthly audit of misdirected claims. The tool provided included one sample misdirected claim as evidence that that the tool is in use.</p> <p>-A dashboard titled "Claims-Misdirected Claims Processed within 14 days (10 Working Days)" (Attachment E) which tracks timeframes for processing misdirected claims. The report includes a monthly comparison for January 2016 through April 2016. Compliance rates reported 97.86%-99.40% as evidence that the MCP is meeting its 95% goal.</p> <p>This finding is closed.</p>

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	<p>IPA is financially responsible for some negotiated claims for Medi-Cal Members assigned to a capitated IPA. Services delegated to IPAs are listed within a Division of Financial Responsibility document.</p> <p>The Plan's Claims Configuration Unit is responsible for updating and maintaining the Diamond Core Claims Systems. Services that are IPAs responsibility are configured at the procedure code level. A claim line that is IPAs responsibility will automatically deny with a corresponding denial reason code. Additionally, the Plan's Member eligibility files designate which IPA a specific Member is assigned to.</p> <p>Process: When a claim is received for an IPA responsible service, the Plan incorporates an auto-adjudication feature to deny the claim on the next business day of receipt. On the following business day, a batch print job is generated for all claims denied as IPA responsible services and an automated notification is sent to a designated clerical team member. The clerical team member prints pre-designated cover letters related to each claim. Please see <i>Deficiency 3.5.2 – Attachment C – Misdirected</i></p>			

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	<p><i>Claim Process.</i></p> <p>Reconciliation and Validation: The clerical team member matches each cover letter with the corresponding claim print(s) using a corresponding document control number (DCN) that is pre-printed on each cover letter and claim. Additionally, manual claim counts are performed to ensure each claim that will be mailed to specific IPA is included.</p> <p>Mailing: Upon completion of matching all claims to their respective cover letters, the clerical team member places all cover letters and misdirected claims into envelopes that will be mailed to each IPA. Misdirected claims are forwarded to IPAs on each business day following denial.</p> <p>Check Run and Remittance Advice (RA): The Plan performs a check run twice weekly, in which payments and RA denial notices are produced and mailed to providers.</p> <p>The Plan's June 9, 2016 follow-up response.</p>			

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	<p>The Plan ensures correct handling of misdirected claims by a) developing a monthly audit to ensure claims are forwarded to the proper IPA who is responsible for payment of the claim and b) that such claims are forwarded within 10 working days following claim receipt.</p> <p>Monthly Audits Beginning July 2016, the Plan's Claims Department shall develop and perform a monthly audit consisting of the below procedures:</p> <ol style="list-style-type: none"> 1. Sample a targeted selection of 5 misdirected claims forwarded to each IPA during the prior month. 2. Review each claim for timeliness, processing accuracy, and assurance that it was forwarded to the correct IPA recipient. This is validated by comparing the IPA listed on each cover letter to the members assigned IPA within the claim system. 3. When a claim is forwarded beyond the regulatory time limit, the Claims Department shall perform a root cause analysis to determine the cause by taking the necessary steps: <ol style="list-style-type: none"> a. Take required action to resolve the deficiency b. Perform verification that the 			

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	<p>deficiency is corrected each subsequent month</p> <p>4. When a claim is forwarded to the incorrect recipient, the Claims Department shall perform a root cause analysis to determine the cause by taking the necessary steps:</p> <ul style="list-style-type: none"> a. Take required action to resolve the deficiency b. Perform verification that the deficiency is corrected each subsequent month <p>An audit tool shall be utilized to score each sampled misdirected claim. Please see <i>Deficiency 3.5.2 – Attachment D – Misdirected_Claims_Audit Tool</i>. The tool shall be used to:</p> <ul style="list-style-type: none"> a. Measure 10-day turn around requirement and; b. Validate the claim was forwarded to the correct recipient. <p>Oversight and Monitoring As of May 2016, the Plan added Misdirected Claim results (beginning January 2016) to its monthly Compliance Dashboard. This dashboard is published to the Plan’s senior leadership and the Compliance Department. Please see <i>Deficiency 3.5.2 – Attachment E – Dashboard</i></p>			

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	<p><i>Performance Monitoring Report</i> If results are less than 95% within 10 working days then the Claims Manager shall draft an internal corrective action plan (CAP) and resolve root cause deficiencies. Additionally, root cause deficiencies are added to the monthly audit criteria for ongoing validation.</p>			
4. Members' Rights				
<p>4.3.1 TIMELY REPORTING OF SECURITY INCIDENTS The verification study revealed in three cases, the Plan did not report security incidents within 72 hours of discovery. During the audit period, the Plan did not have a monitoring system to properly report security incidents in a timely manner. Recommendation: The Plan shall implement a monitoring and reporting system to properly ensure the Plan reports security incidents within 72 hours of discovery.</p>	<p>Remediation Activity: In September 2015, the Compliance department hired a new Manager to oversee the Special Investigations Unit (SIU) which is responsible for handling all allegations involving privacy incidents. In addition, the SIU Manager recently hired new Team Members to assist with intake and case investigations. Currently, the SIU is made up of a Manager, two (2) Business Analysts and two (2) Specialists. SIU implemented new processes to ensure the Plan reports security incidents within the specified timeframes. This issue was identified prior to the audit, while pulling case specific information for the universe of cases requested for the audit. As a result, the SIU immediately re-educated Team Members and implemented new processes to</p>	<p>Policy & Procedures: N/A Training: All staff in the SIU shall be re-educated and trained on the Plan's reporting requirements, including timeliness for reporting on May 11, 2016. Please see the following training materials: a. <i>Deficiency 4.3.1 – Attachment D - PRO_CMP 04n – Notification of Privacy Incident and Breach, Risk Assessment and Reporting</i> b. <i>Deficiency 4.3.1 – Attachment E – SIU</i></p>	<p>All staff in the SIU shall be re-educated and trained on the Plan's reporting requirements, including timeliness for reporting on May 11, 2016.</p>	<p>5/10/2016 – IEHP submitted: -A report titled "Privacy Incidents from October 1, 2015 through April 28, 2016" (Attachment A) which demonstrates the MCP is tracking timeliness of reporting within the 72-hour timeframe. -P&P #PRO_CMP 04n titled: Notification of Privacy Incident and Breach, Risk Assessment and Reporting" (revised 01/01/16) (Attachment D) which demonstrates alignment with the contractual requirements. -A document titled "SIU Reporting Timeframe Workflow" (Attachment E) which includes the 72-hour requirement for reporting. -The "Daily Reportable Case Update Template, (Attachment C) where business analysts are required to send a daily update of reportable cases as part of the plan's monitoring system. 5/25/16 - IEHP submitted additional</p>

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	<p>address this finding. The attached chart reflects the Plan's timeliness and accurate reporting of privacy incidents from October 1, 2015 through April 28, 2016. <i>Please see Deficiency 4.3.1. Attachment A – Privacy Incidents Report.</i></p> <p>Process Change: On July 29, 2015, the SIU implemented daily huddles as a forum to triage cases received the previous business day. During the huddle, SIU staff discuss issues for each case to determine a plan of action and identify whether the case is reportable. If reportable, staff shall determine the timeframe for reporting and document the date on the SIU – Case Summary Form. The investigator assigned is cognizant of the timeframe at the onset of the investigation and they can monitor and ensure timely reporting. <i>Please see Deficiency 4.3.1 - Attachment B – Case Huddle Sign-In Sheet Template.</i></p> <p>In August 2015, SIU implemented a daily notification of reportable cases as another monitoring system to ensure timely reporting. The Business Analysts are responsible for sending out an email each day with an update of all reportable cases due within the following three (3) business days,</p>	<p><i>Reporting Timeframes Workflow</i></p> <p>c. <i>Deficiency 4.3.1 – Attachment F - Training Calendar Appointment</i></p>		<p>documentation:</p> <p>-Privacy Incidents Report for time period October 1, 2015 through April 28, 2016 (Attachment A) as evidence the plan is actively monitoring timeframes for privacy incidence reporting. In this report, IEHP reviewed 9 cases for timely reporting. 8 cases were within the 72-hour required timeframes.</p> <p>-An email as evidence that SIU training was scheduled for 5/11/16 (Attachment F).</p> <p>6/9/2016 - IEHP submitted additional documentation:</p> <p>-Audit tool template which monitors timely reporting of privacy incidents.</p> <p>-A sample audit report of the tool in use dated June 6, 2016 which shows recent security incidents were reported timely.</p> <p>This finding is closed.</p>

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	<p>including timelines for reporting and whether timeline was met for cases reported the previous business day. This notification is emailed to all SIU staff, including the Manager and the Compliance Officer. <i>Please see Deficiency 4.3.1 – Attachment C – Daily Reportable Case Update Template.</i></p> <p>Quality Assurance: Beginning May 2016, the SIU Manager shall complete a case audit of all reportable cases on a weekly basis.</p>			
<p>4.3.2 REPORTING OF SECURITY INCIDENTS TO DHCS OFFICERS The verification study revealed in 10 security incidents, the Plan did not notify the DHCS Contracting Officer and Information Security Officer. The Plan only notified the DHCS Privacy Officer. During the audit period, the Plan did not have a monitoring system to properly notify all three DHCS officers. Recommendation: The Plan shall implement a monitoring and reporting system to properly ensure</p>	<p>Remediation Activity: In September 2015, the Compliance Department hired a new Manager to oversee the Special Investigations Unit (SIU) which is responsible for handling all allegations involving privacy incidents. In addition, the SIU Manager recently hired new Team Members to assist with intake and case investigations. Currently, the SIU is made up of a Manager, two (2) Business Analysts and two (2) Specialists.</p> <p>SIU staff was trained on the Plan’s obligations for reporting all security incidents (24 hour, 72 hour and 10 working days) to DHCS Privacy Officer, DHCS Information Security Officer and DHCS Contract Manager.</p>	<p>Policy & Procedures: N/A</p> <p>Training: All staff in the SIU shall be re-educated and trained on the Plan’s reporting requirements, including notification of privacy incidents (24 hour, 72 hour and 10 working days) to DHCS Privacy Officer, DHCS Information Security Officer and DHCS Contract Manager, on May 11, 2016.</p> <p>Please see the following</p>	<p>All staff in the SIU shall be re-educated and trained on the Plan’s reporting requirements, including notification of privacy incidents (24 hour, 72 hour and 10 working days) to DHCS Privacy Officer, DHCS Information Security Officer and DHCS Contract Manager, on May 11, 2016.</p>	<p>5/10/2016 – IEHP submitted:</p> <p>-Privacy Incidents Report for time period October 1, 2015 through April 28, 2016 (Attachment A). In this report IEHP has indicated that during this time period, the Plan received nine (9) reportable privacy incidents cases and all of them were reported to the three agencies timely.</p> <p>-P&P #PRO_CMP 04n titled Notification of Privacy Incident and Breach, Risk Assessment and Reporting) (revised on 01/01/2016) (Attachment B) which demonstrates that privacy incidents are reported to following officers: DHCS MCOD Contracting Officer, DHCS Privacy Officer, and DHCS Information Security Officer.</p> <p>-A document titled “Special Investigation Unit (SIU) Reporting Timeframes” (Attachment C) which is a workflow chart to ensure fraud cases</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
<p>the Plan reports security incidents to the DHCS MMCD Contracting Officer, DHCS Privacy Officer, and DHCS Information Security Officer.</p>	<p>This issue was identified prior to the audit, while pulling case specific information for the universe of cases requested for the audit. As a result, the SIU Manager immediately re-educated Team Members to address this finding. The Business Analysts who make the report to DHCS will continue to carbon copy the SIU Manager and Compliance Officer in the email notifications as a monitoring system to ensure the three (3) officers are notified. The attached chart reflects the Plan's timeliness and accurate reporting of privacy incidents from October 1, 2015 through April 28, 2016. Please see <i>Deficiency 4.3.2 - Attachment A – Privacy Incidents Report</i>.</p> <p>Process Change: As the assigned investigators on reportable cases, the Business Analysts are responsible for reporting privacy incidents to DHCS. Effective October 2015, rather than simply responding to the last email chain, Business Analysts were instructed to ensure that DHCS Privacy Officer, DHCS Information Security Officer and DHCS Contract Manager were each again included in the notification (24 hour, 72 hour and 10 working days).</p>	<p>training materials:</p> <ul style="list-style-type: none"> a. <i>Deficiency 4.3.2 – Attachment B– PRO_CMP 04n – Notification of Privacy Incident and Breach, Risk Assessment and Reporting</i> b. <i>Deficiency 4.3.2 – Attachment C - SIU Reporting Timeframes Workflow</i> c. <i>Deficiency 4.3.2. – Attachment D - Training Calendar Appointment.</i> 		<p>are reported to the following officers: DHCS MCOD Contracting Officer, DHCS Privacy Officer, and DHCS Information Security Officer.</p> <p>6/9/2016 - IEHP submitted additional documentation:</p> <p>-Audit tool template (Attachment E) which is designed to ensure all cases are reported to the three agents.</p> <p>-A sample audit report of the tool in use dated June 6, 2016 (Attachment F) which shows recent security incidents were reported timely to the DHCS Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer.</p> <p>This finding is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>Quality Assurance: Beginning May 2016, the SIU Manager shall complete a case audit of all reportable cases on a weekly basis.</p>			
<p>4.3.3 TIMELY SUBMISSION OF THE FULL INVESTIGATION REPORT The verification study revealed that in five cases, the Plan did not submit the full investigation report within 10 working days after discovery of security incident. During the audit period, the Plan did not have a monitoring system to issue a full investigation report in a timely manner. Recommendation: The Plan shall implement a monitoring and reporting system to properly ensure the Plan submits a full investigation report within 10 working days after discovery of security incident.</p>	<p>Remediation Activity: In September 2015, the Compliance Department hired a new Manager to oversee the Special Investigations Unit (SIU) which is responsible for handling all allegations involving privacy incidents. In addition, the SIU Manager recently hired new Team Members to assist with intake and case investigations. Currently, the SIU is made up of a Manager, two (2) Business Analysts and two (2) Specialists. SIU implemented new processes to ensure the Plan reports security incidents within the specified timeframes. This issue was identified prior to the audit, while pulling case specific information for the universe of cases requested for the audit. As a result, the SIU Manager immediately re-educated Team Members and implemented new processes to address this finding. The attached chart reflects the Plan's timeliness and accurate reporting of privacy incidents from October 1, 2015 through April 28, 2016. Please see <i>Deficiency 4.3.3 - Attachment A</i> –</p>	<p>Policy & Procedures: N/A Training: All staff in the SIU shall be re-educated and trained on the Plan's reporting requirements, including timelines for reporting on May 11, 2016. Please see the following training materials: <i>a. Deficiency 4.3.3 – Attachment D – PRO_CMP 04n – Notification of privacy Incident and Breach, Risk Assessment and Reporting</i> <i>b. Deficiency 4.3.3 – Attachment E - SIU Reporting Timeframes Workflow</i> <i>c. Deficiency 4.3.3 – Attachment F - Training Calendar</i></p>	<p>All staff in the SIU shall be re-educated and trained on the Plan's reporting requirements, including timelines for reporting on May 11, 2016.</p>	<p>5/10/2016 – IEHP submitted: -Privacy Incidents Report of 9 cases (Attachment A) for the time period October 1, 2015 through April 28, 2016 as evidence that the plan is monitoring timely privacy incident reporting. 9 of 9 cases were reported within the required 10-day timeframe. -A copy of a template titled "Daily Reportable Case Update" (Attachment C) which is a daily notification of reportable cases sent to the compliance business analyst. This is part of plan's monitoring system. -P&P #PRO_CMP 04n titled Notification of Privacy Incident and Breach, Risk Assessment and Reporting) (Attachment D) to ensure the Plan reports security incidents within the required timeframes. -A document titled "Special Investigation Unit (SIU) Reporting Timeframes" (Attachment E) which is a workflow chart to ensure fraud cases are processed timely. -An email as evidence that SIU training was scheduled for 5/11/16 (Attachment F).</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p><i>Privacy Incident Report.</i></p> <p>Process Change: On July 29, 2015, the SIU implemented daily huddles as a forum to triage cases which were received the previous business day. During the huddle, SIU staff discusses the issues for each case, determine a plan of action and identify whether the case is reportable. If reportable, staff shall determine the timeframe for reporting and document the date on the SIU – Case Summary Form. The investigator assigned is cognizant of the timeframe at the onset of the investigation and they can monitor and ensure timely reporting, if appropriate. Please see <i>Deficiency 4.3.3 - Attachment B- Case Huddle Sign-In Sheet Template.</i></p> <p>In August 2015, SIU implemented a daily notification of reportable cases as another monitoring system to ensure timely reporting. The Business Analysts are responsible for sending out an email each day with an update of all reportable cases due within the following three (3) business days, including timelines for reporting and whether timeline was met for cases reported the previous business day. This notification is emailed to all SIU staff, including the Manager, and</p>	<p><i>Appointment.</i></p>		<p>6/9/2016 – IEHP submitted the additional documentation:</p> <p>-Audit tool template (Attachment G) which is designed to ensure all cases are reported within the required timeframes.</p> <p>-A sample audit report of the tool in use dated June 6, 2016 (Attachment H) which shows recent security incidents were reported timely within the required time frame.</p> <p>This finding is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>the Compliance Officer. Please see <i>Deficiency 4.3.3 - Attachments C– Daily Reportable Case Update Template</i>.</p> <p>Quality Assurance: Beginning May 2016, the SIU Manager shall complete a case audit of all reportable cases on a weekly basis.</p>			
<p>4.3.4 SUBMISSION OF THE FULL INVESTIGATION REPORT TO DHCS OFFICERS</p> <p>The verification study revealed that in 11 cases, the Plan did not submit the full investigation report to the DHCS Contracting Officer and DHCS Information Security Officer. The Plan only submitted the full investigation report to the DHCS Privacy Officer. During the audit, the Plan did not have a monitoring system to issue a full investigation report to all three DHCS officers.</p> <p>Recommendation: The Plan shall implement a monitoring and reporting system to properly ensure</p>	<p>Remediation Activity: In September 2015, the Compliance Department hired a new Manager to oversee the Special Investigations Unit (SIU) which is responsible for handling all allegations involving privacy incidents. In addition, the SIU Manager recently hired new Team Members to assist with intake and case investigations. Currently, the SIU is made up of a Manager, two (2) Business Analysts and two (2) Specialists.</p> <p>SIU staff was trained on the Plan’s obligations for reporting all security incidents (24 hour, 72 hour and 10 working days) to DHCS Privacy Officer, DHCS Information Security Officer and DHCS Contract Manager. This issue was identified prior to the audit, while pulling case specific information for the universe of cases requested for the audit. As a result, the SIU Manager immediately re-</p>	<p>Policy & Procedures: N/A</p> <p>Training: All staff in the SIU shall be re-educated and trained on the Plan’s reporting requirements, including notification of privacy incidents (24 hour, 72 hour and 10 working days) to DHCS Privacy Officer, DHCS Information Security Officer and DHCS Contract Manager, on May 11, 2016.</p> <p>Please see the following training materials:</p> <p>a. <i>Deficiency 4.3.4 – Attachment B – PRO_CMP 04n –</i></p>	<p>All staff in the SIU shall be re-educated and trained on the Plan’s reporting requirements, including notification of privacy incidents (24 hour, 72 hour and 10 working days) to DHCS Privacy Officer, DHCS Information Security Officer and DHCS Contract Manager, on May 11, 2016.</p>	<p>5/10/2016 – IEHP submitted:</p> <p>-Privacy Incidents Report from October 1, 2015 through April 28, 2016 (Attachment A). In this report IEHP has indicated that during this time period, the Plan received nine (9) reportable privacy incidents cases and all of them were reported to the three agencies timely.</p> <p>-P&P #PRO_CMP 04n titled Notification of Privacy Incident and Breach, Risk Assessment and Reporting) (revised on 01/01/2016) (Attachment B) to ensure the Plan reports security incidents to all three agencies.</p> <p>-A document titled “Special Investigation Unit (SIU) Reporting Timeframes” (Attachment E) which is workflow chart to ensure fraud cases are reported to all three agencies.</p> <p>6/9/2016 - IEHP submitted additional documentation:</p> <p>-Audit tool template (Attachment E) which is designed to ensure all cases are reported to the</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
<p>the Plan submits the full investigation report to the DHCS MMCD Contracting Officer, DHCS Privacy Officer, and DHCS Information Security Officer.</p>	<p>educated Team Members to address this finding. The Business Analysts who make the report to DHCS shall continue to carbon copy the SIU Manager and Compliance Officer in the email notifications as a monitoring system to ensure the three (3) officers are notified. The attached chart reflects the Plan's timeliness and accurate reporting of privacy incidents from October 1, 2015 through April 28, 2016. Please see <i>Deficiency 4.3.4 - Attachment A – Privacy Incidents Report</i>.</p> <p>Process Change: As the assigned investigators on reportable cases, the Business Analysts are responsible for reporting privacy incidents to DHCS. Effective October 2015, rather than simply responding to the last email chain, Business Analysts were instructed to ensure that DHCS Privacy Officer, DHCS Information Security Officer and DHCS Contract Manager were each again included in the notification (24 hour, 72 hour and 10 working days).</p> <p>Quality Assurance: Beginning May 2016, the SIU Manager shall complete a case audit of all reportable cases on a weekly basis.</p>	<p><i>Notification of Privacy Incident and Breach, Risk Assessment and Reporting</i></p> <p>b. <i>Deficiency 4.3.4 – Attachment C - SIU Reporting Timeframes Workflow</i></p> <p>c. <i>Deficiency 4.3.4 – Attachment D - Training Calendar Appointment</i></p>		<p>three agents.</p> <p>-An audit report updated on June 6, 2016 (Attachment F) which shows recent security incidents were reported timely to the DHCS Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer.</p> <p>This finding is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
5. Quality Management				
<p>5.2.1 TIMELY FILING OF REPORTS TO APPROPRIATE AUTHORITIES</p> <p>The Plan did not properly file the MBOC 805 report within the 15 days reporting timeframe in four cases. In addition, one 805.01 report was not filed.</p> <p>Recommendation:</p> <p>The Plan shall develop and implement a process to report serious quality deficiencies and adhere to the Medical Board of California reporting guidelines.</p>	<p>Remediation Activity:</p> <p>IEHP Provider Services department shall ensure that all Providers who are offered the right to appeal shall be offered appeal rights counting from the date of the letter is signed and mailed to the Provider.</p> <p>Process Change:</p> <p>IEHP Provider Services Administrative Assistant (AA) shall be added to the review process to ensure that dates are correct before they are sent to the Provider.</p> <p>Quality Assurance:</p> <p>IEHP Provider Services AA shall be added to the review process to ensure the dates are correct before the letters are signed and sent to the Provider.</p>	<p>Policy & Procedures:</p> <p>Please see <i>Deficiency 5.2.1 – Attachment A - PRO_CRE 10 - IEHP's Appeals Process for Practitioners</i>. All updates to the policy have been highlighted.</p> <p>Training:</p> <p>Training was conducted to ensure all notifications included appeal rights. IEHP Credentialing Coordinators who prepare the Provider notification letters in addition to the Provider Services AA were trained on February 9, 2016. Please see <i>Deficiency 5.2.1 – Attachment B – Meeting Agenda and Packet</i>.</p>	<p>Training was conducted to ensure all notifications included appeal rights. IEHP Credentialing Coordinators who prepare the provider notification letters in addition to the Provider Services AA were trained on February 9, 2016. Training Completed.</p>	<p>5/10/2016 – IEHP submitted:</p> <p>-Updated P&P (# PRO_CRE 10 titled IEHP's Appeals Process for Practitioners) (revised 1/1/16) (Attachment A) which indicates the plan's Medical Director or designee will notify the Credentialing Manager to file a 805.01 report within the required timeframe (page 7).</p> <p>This finding is closed.</p>
6. Administrative and Organizational Capacity				
<p>6.3.1 TIMELY REPORTING OF SUSPECTED FRAUD AND/OR ABUSE CASES</p> <p>The verification study revealed that in five cases</p>	<p>Remediation Activity:</p> <p>In September 2015, the Compliance Department hired a new Manager to oversee the Special Investigations Unit (SIU) which is responsible for handling all allegations involving</p>	<p>Policy & Procedures:</p> <p>N/A</p> <p>Training:</p> <p>All staff in the SIU shall</p>		<p>5/10/2016 – IEHP submitted:</p> <p>-A template titled "Daily Reportable Case Update" (Attachment B) which is a daily notification of reportable cases sent to the compliance business analyst. This part of plan's</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments				
<p>the Plan did not report the results of the preliminary investigation of suspected fraud and/or abuse cases to DHCS within 10 working days.</p> <p>Recommendation: The Plan shall ensure it resolves its staffing issues and implement a monitoring system to report fraud and/or abuse cases to DHCS within 10 working days of the date the Plan first becomes aware of such activity.</p>	<p>Fraud, Waste and Abuse (FWA). In addition, the SIU Manager recently hired new staff to assist with intake and case investigations. Currently, the SIU is made up of a Manager, two (2) Business Analysts and two (2) Specialists.</p> <p>SIU implemented new processes to ensure the Plan reports suspected fraud and/or abuse cases to DHCS within 10 working days from the date the Plan first became aware of such activity. This issue was identified prior to the audit, while pulling case specific information for the universe of cases requested for the audit. As a result, the SIU Manager immediately re-educated Team Member on the Plan's obligations for reporting to DHCS and on the new processes which were implemented to address this finding. The following chart reflects the Plan's timeliness of FWA reportable cases from October 1, 2015 through April 15, 2016:</p> <table border="1" data-bbox="443 1193 894 1334"> <thead> <tr> <th data-bbox="443 1193 657 1287"># of Cases Received</th> <th data-bbox="657 1193 894 1287"># of Cases Timely 10-day Report</th> </tr> </thead> <tbody> <tr> <td data-bbox="443 1287 657 1334">53</td> <td data-bbox="657 1287 894 1334">53</td> </tr> </tbody> </table> <p>Process Change:</p>	# of Cases Received	# of Cases Timely 10-day Report	53	53	<p>be re-educated and trained on the Plan's reporting requirements, including timelines for reporting on May 11, 2016.</p> <p>Please see the following training materials:</p> <ul style="list-style-type: none"> a. <i>Deficiency 6.3.1 – Attachment C - PRO_CMP 03b – Fraud Waste and Abuse Program – Reporting Procedures – State programs</i> b. <i>Deficiency 6.3.1 – Attachment D - SIU Reporting Timeframes Workflow</i> c. <i>Deficiency 6.3.1 – Attachment E - Training Calendar Appointment.</i> 		<p>monitoring system.</p> <p>-Revised P&P #PRO_CMP 03b titled "Fraud Waste and Abuse Program – Reporting Procedures – State programs" (1/1/16) (Attachment C) which shows IEHP process to report fraud/abuse cases to DHCS according to the required timeframes (page 3).</p> <p>-A document titled "Special Investigation Unit (SIU) Reporting Timeframes" (Attachment D) which is a workflow chart to ensure fraud cases are processed timely.</p> <p>-An email as evidence that SIU training was scheduled for 5/11/16 (Attachment E).</p> <p>This finding is closed.</p>
# of Cases Received	# of Cases Timely 10-day Report							
53	53							

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>On July 29, 2015, the SIU implemented daily huddles as a forum to triage cases which were received the previous business day. During the huddle, SIU staff discusses the issues for each case, determine a plan of action and identify whether the case is reportable. If reportable, staff will determine the timeframe for reporting and document the date on the SIU – Case Summary Form. The investigator assigned is cognizant of the timeframe at the onset of the investigation and they can monitor and ensure timely reporting, if appropriate. <i>Please see Deficiency 6.3.1 - Attachment A – Case Huddle Sign-In Sheet Template.</i></p> <p>In August 2015, SIU implemented a daily notification of reportable cases as another monitoring system to ensure timely reporting. The Business Analysts are responsible for sending out an email each day with an update of all reportable cases due within the following three (3) business days, including timelines for reporting and whether timeline was met for cases reported the previous business day. This notification is emailed to all SIU staff, including the Manager, and the Compliance Officer. <i>Please see Deficiency 6.3.1 – Attachment B – Daily Reportable Case Update</i></p>			

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p><i>Template.</i></p> <p>Quality Assurance: Beginning May 2016, the SIU Manager shall complete a case audit of all reportable cases on a weekly basis.</p>			
<p>6.3.2 NOTIFICATION OF EXCLUDED PROVIDER TO DHCS The Plan does not have a policy and procedure to notify DHCS within 10 working days of removing an excluded provider from its provider network and to confirm the provider is no longer receiving payment from the Medi-Cal program.</p> <p>Recommendation: The Plan shall develop and implement policies and procedures to notify DHCS within 10 working days of removing an excluded provider from its provider network and to confirm the provider is no longer receiving payment from the Medi-Cal program.</p>	<p>Remediation Activity: IEHP updated the existing Compliance Policy and Procedure <i>PRO_CMP 02r</i> to reflect that IEHP Compliance Department shall report to DHCS within 10 working days the removal of a suspended, excluded or terminated Provider from its Provider network and shall confirm to DHCS that the Provider shall no longer receive payments in connection with the Medicaid program. This policy shall take effect June 1, 2016. Please see <i>Deficiency 6.3.2 – Attachment A- Provider and Subcontractor Suspensions_ Terminations_ or Decertifications</i></p> <p>Process Change: Current process exists to notify the Compliance department of sanctioned and excluded Provider. The existing process was updated to include the Compliance department reporting the status of sanctioned and excluded Provider to DHCS (as reflected in <i>Deficiency 6.3.2 – Attachment A- Provider and Subcontractor</i></p>	<p>Policy & Procedures: Please see <i>Deficiency 6.3.2 – Attachment A- Provider and Subcontractor Suspensions_ Terminations_ or Decertifications</i>. All updates to the policy have been highlighted.</p> <p>Training: State Programs Unit (SPU) Compliance department and Compliance Administration Unit staff will be re-educated on the revised policy & procedure and process on May 9, 2016.</p>	<p>State Programs Unit (SPU) Compliance department and Compliance Administration staff will be re-educated on the revised policy & procedure and process on May 9, 2016.</p>	<p>5/10/2016 – IEHP has submitted:</p> <p>-Revised P&P #PRO-CMP02r titled “Provider and Subcontractor Suspensions, Terminations or Decertification” (5/1/16) (Attachment A) which demonstrates IEHP process to report excluded providers to DHCS according to the requirements.</p> <p>This finding is closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<i>Suspensions_Terminations_or Decertifications)</i>			

Submitted by: **Rebecca Mayer**
 Title: **State Programs Compliance Manager**

Date: **05/06/2016**