



JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

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

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 April 7, 2014 through April 18, 2014. The audit covered the review period of January 1, 2013 through December 31, 2013.

On May 20, 2015, the MCP provided DHCS with the second response to its Corrective Action Plan (CAP) originally issued on February 6, 2014 regarding remaining open items. These deficiencies were reviewed and provisionally closed. These items will be considered at the next medical audit to verify efficiency and productivity of the implemented policy and procedure.

This report will serve as DHCS's 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, contact Ms. Dana Durham, Chief, Contract Compliance Section, at (916) 5043-5233 or CAPMonitoring@dhcs.ca.gov.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Contract Compliance Section
Managed Care Quality and Monitoring Division

Encl.

cc: OZ Kamara, Contract Manager
Department of Health Care Services
Medi-Cal Managed Care Division
P.O. Box 997413, MS 4005
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Bcc:

Farzaneh Aflatooni, Analyst
Plan Monitoring Unit, MS 4417
Managed Care Quality and Monitoring Division

**ATTACHMENT A
CAP Response Form**

Plan Name: Inland Empire Health Plan

Review/Audit Type: Medical Review

Review Period: January 1, 2013 through December 31, 2013

MCPs are required to provide a CAP and respond to all documented deficiencies within 30 calendar days of receiving a medical audit, survey, or any other special reviews requiring a CAP. 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
1. Utilization Management				
<p>1.2 – PRIOR AUTHORIZATION REVIEW REQUIREMENTS The Plan did not comply with contract requirements for timely processing of pharmacy Prior Authorizations. The Plan did not routinely meet the</p>	<p>Remediation Activity: IEHP has accelerated the hiring and training effort to ensure adequate staff is available to review Prior Authorizations (PA). In addition, due to the new Universal PA requirement (SB866), IEHP has changed its PA policy effective January 1, 2015 (soft launch on January 1, 2015 and final effective date on March 2, 2015). The new policy</p>	<p>Policy & Procedures: Please see Deficiency 1.2 – Attachment B, IEHP Pharmaceutical Services Manual MED PHR 5 Prior Authorization for Non-Formulary Drugs – Non-Medicare. All updates to policies have been highlighted.</p>	<p>10/28/15 – 10/30/14 Team Training Completed. 2/22/2015 – Completion of remediation activities leading to full compliance.</p>	<p>3/6/2015 – Attachments A and B submitted by IEHP were reviewed. The MCP demonstrated changes to ensure the process complies. This deficiency is deemed closed.</p>

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<p>24-hour time frame for authorization of pharmaceuticals, as specified in the Contract. The majority of the pharmacy exemption requests (PER) prior authorizations reviewed was outside the 24-hour turnaround time specified in the Contract.</p> <p>Recommendation: Adhere to the Plan's policy, Prior Authorization for Non-Formulary Drugs-Non-Medicare (MED_PHR 5), and the Contract for a 24-hour time frame for pharmacy authorizations.</p>	<p>requires IEHP to review and provide a decision within 24 hours of receipt of the PA request, and no PA can be deferred. Under the new rules, Physicians are required to submit adequate information for IEHP to make a determination on the initial submission. Previously, IEHP has been proactive in reaching out to its Physicians for each PA submitted, which generates a backlog of PAs due to multiple attempts. Based on the new policy, IEHP is committed to turn around a PA within 1 business day. As of February 22, 2015, IEHP is compliant with this requirement. Please see Deficiency 1.2 – Attachment A. IEHP will continue to monitor the PA volume and staffing ratio necessary to stay compliant with this requirement.</p> <p>Process Change: In addition to the discussion above, IEHP implemented the following steps to ensure turnaround time compliance: The team was restructured to streamline operations, and allow the management team to predict staffing needs; Enhanced its staffing tracker to better predict its staffing needs; and Revised its training program to ensure staffing planning is optimized.</p> <p>Quality Assurance: On a daily basis, team productivity and performance (Turnaround Time) are monitored by the Operations Manager.</p>	<p>Training: Team training on the new Universal PA form, policy and procedure was conducted on October 28 – 30, 2014. Each morning, productivity and performance for the prior day and the expectation for the day is discussed and addressed by the Director of Operations.</p>		

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	<p>In addition, daily productivity and performance is reviewed throughout the day by the Management team and the Director of Operations tracks and anticipates the staffing requirement based on the volume and other factors to ensure compliance with the turnaround time requirement.</p>			
<p>1.3 – REFERRAL TRACKING SYSTEM</p> <p>1.3.1 - The Plan’s policy & procedure and Provider Manual did not reflect the monitoring of the Primary Care Provider (PCP) referral log on a routine basis.</p> <p>Recommendation: Amend Provider Manual and Policies to reflect monitoring of the PCP referral log by IEHP on a routine basis.</p>	<p>Remediation Activity: Provider Manual MC 14C1 Review Procedures - Primary Care Physician (PCP) Referrals has been updated to reflect the current process for monitoring the PCP referral log on a routine basis under Procedure B. Provider Manual MC 7A PCP and IPA Medical Record Requirements has been updated to reflect current process for monitoring the PCP referral log on a routine basis under Procedure Monitoring subsection J, 1-4.</p> <p>Process Change: N/A</p> <p>Quality Assurance: A QA review is to occur upon review of the PCP referral logs per policy. The Interim Audit includes review of the referral log and/or the process. The referral log is also reviewed at the Facility Site Review per policy MC 6A Site Review and Medical Records Review. Please see Deficiency 1.3.1 – Attachment C. The Director of Quality</p>	<p>Policy & Procedures: Please see Deficiency 1.3.1 – Attachments A and B for the updated policies in Provider Manual MC 14C1 Review Procedures - Primary Care Physician (PCP) Referrals and MC 7A PCP and IPA Medical Record Requirements. All updates to policies have been highlighted.</p> <p>Training: The Quality Management Team was educated on revisions to policies on March 3, 2015 to align with current practice. Clarification was updated in the Provider Manual Policy and Procedure on February 27, 2015.</p>	<p>3/3/2015 – QM Team Training was conducted.</p> <p>2/27/15 – Updates to the Provider Manual PnPs were completed.</p>	<p>3/6/2015 – Attachments A and B submitted by IEHP were reviewed. The MCP made changes to its provider manual and policies & procedures.</p> <p>This deficiency is deemed closed.</p>

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	<p>Management and Quality Management Nurse Manager will monitor oversight activities and ensure activities are consistent with policies & procedures. IEHP will conduct an annual review of all Quality Management related policies to ensure procedures are accurately reflected.</p>			
<p>1.3.2 - The Plan has not implemented a system to track open or unused prior authorization referrals.</p> <p>Recommendation: Implement a process to track open and unused referrals, as stipulated in the Contract.</p>	<p>Remediation Activity: IEHP implemented a tracking process for open and unused prior authorization referrals. Please see Deficiency 1.3.2 – Attachment A, policy PRO HAR 17 Referral Tracking System Reporting.</p> <p>Process Change: IEHP will run quarterly reports comparing authorizations to claims submissions for ongoing monitoring.</p> <p>Quality Assurance: N/A</p>	<p>Policy & Procedures: Please see Deficiency 1.3.2 – Attachment B for the updated Medi-Cal Provider Manual Policy 14A. Utilization Management Delegation and Monitoring. All updates to policies have been highlighted.</p> <p>Training: The IPA network was notified in October 2014 during its Quarterly IPA Meeting regarding the need to develop tracking for open and unused prior authorizations.</p>	<p>3/15/15 – Referral Tracking System in place.</p> <p>10/2014 – IPA Network Training was completed.</p>	<p>3/6/2015 – Attachments A and B submitted by IEHP were reviewed. The Plan followed the recommendation to implement a process for tracking referrals.</p> <p>This deficiency is deemed closed.</p>
<p>1.5 – DELEGATION OF UTILIZATION MANAGEMENT</p> <p>1.5.1 - The Plan did not have clearly defined</p>	<p>Remediation Activity: IEHP will continue to review UM Delegate Approval files on a quarterly basis.</p> <p>Process Change:</p>	<p>Policy & Procedures: Provider Manual policy MC 14B Utilization Management Reporting Requirements “Approval” section was revised to</p>	<p>7/1/2015 – Modified Quarterly Approval File Review Process will begin.</p> <p>4/1/2015 – Quality</p>	<p>3/6/2015 – Attachment A submitted by IEHP was reviewed.</p> <p>This deficiency is deemed closed.</p>

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<p>procedures reflected in the Provider policy & procedure Manual of Approved Referral File reviews of UM Delegates.</p> <p>Recommendation: Amend policies and procedures, including the Provider Manual, to be consistent with current practice with regards to Authorized Referral Audits of UM Delegates</p>	<p>Effective July 1, 2015 quarterly Approval file review will consist of ten (10) complete files instead of five (5) as previously reviewed. Approval file review will no longer be conducted at the Annual Audit. Quarterly review will allow for more of a timely response to IPAs on performance.</p> <p>Quality Assurance: A QA review is to occur upon first submission of ten (10) Approved Referral files from UM Delegates. This review will ensure files are submitted per policy. The Director of Quality Management and Quality Management Manager will monitor oversight activities and ensure activities are consistent with policies & procedures. IEHP will conduct an annual review of all Quality Management related policies to ensure procedures are accurately reflected.</p>	<p>reflect quarterly submission of ten (10) complete Approval Letters with the supporting documentation used to make the decisions. Please see Deficiency 1.5.1 – Attachment A. All updates to policies have been highlighted.</p> <p>Training: Distribution and delineation of the revised Policy and Procedure with appropriate training will be delivered to the Quality Management Team by April 1, 2015. Effective April 1, 2015 all IPA's will be notified of revised Policy and Procedure to be implemented on July 1, 2015.</p>	<p>Management Team Training to be completed.</p> <p>4/1/2015 – Completion of notification of IPA Network of revised PnP to be implemented on 7/1/2015.</p>	
<p>1.5.2 - The Plan's Provider Manual and policies were not consistent with current practice with regards to monitoring and oversight of PCP referral logs for Primary Care Providers</p>	<p>Remediation Activity: Provider Manual policy MC 14C1 Primary Care Physician (PCP) Referrals has been updated to reflect the current process for monitoring the PCP referral log on a routine basis. Please see Deficiency 1.5.2 – Attachment A. Provider Manual policy MC 7A PCP and</p>	<p>Policy & Procedures: Please see updated policies in Provider Manual MC 14C1 Review Procedures - Primary Care Physician (PCP) Referrals and MC 7A PCP and IPA Medical Record</p>	<p>2/27/2015 – PnP Revisions were completed.</p> <p>3/3/2015 – QM Team training completed.</p>	<p>3/6/2015 – Attachments A, B, and C submitted by IEHP were reviewed. The MCP incorporated amendments to its policies and procedures.</p> <p>This deficiency is deemed closed.</p>

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<p>within the Independent Practice Association network.</p> <p>Recommendation: Amend policies and procedures to be consistent with current practice with regards to monitoring and oversight to primary care provider referral logs for Primary Care Providers within the Independent Practice Association network.</p>	<p>IPA Medical Record Requirements has been updated to reflect current process for monitoring the PCP referral log on a routine basis under Procedure Monitoring. Please see Deficiency 1.5.2 – Attachment B.</p> <p>Process Change: N/A</p> <p>Quality Assurance: A QA review is to occur upon review of the PCP referral logs per policy. The Interim Audit includes review of the referral log and/or the process. The referral log is also reviewed at the Facility Site Review per policy MC 6A Site Review and Medical Records Review. Please see Deficiency 1.5.2 – Attachment C. The Director of Quality Management and Quality Management Nurse Manager will monitor oversight activities and ensure activities are consistent with policies & procedures. IEHP will conduct an annual review of Quality Management related policies to ensure procedures are accurately reflected.</p>	<p>Requirement as reference above. All updates to policies have been highlighted.</p> <p>Training: The Quality Management Team was educated on revisions to policies on March 3, 2015 to align with current practice. Clarification was updated in the Provider Manual Policy and Procedure on February 27, 2015.</p>		
2. Case Management and Coordination of Care				
<p>2.2 – CALIFORNIA CHILDREN’S SERVICES (CCS) Plan did not provide documentation for coordination of care between PCPs (Primary</p>	<p>Remediation Activity: IEHP has implemented the following remediation activities: Implementation of process to monitor and track CCS-Eligible Members for coordination of care between primary care physicians and specialty providers.</p>	<p>Policy & Procedures: Policy MED_CM 6.a California Children’s Services was updated to reflect the CCS staff’s process for care coordination when</p>	<p>2/21/2014 – Team Training conducted.</p> <p>2/21/2014 – Monitoring and Tracking of CCS-</p>	<p>3/9/2015 – Attachments A, B, C, and D submitted by IEHP were reviewed. Please provide evidence that the updated process to monitor and track all CCS members for coordination of care between PCP and specialty providers is efficiently working.</p>

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<p>Care Physicians) and specialists for all California Children’s Services (CCS).</p> <p>Recommendation: Ensure that all CCS-eligible Members are monitored and tracked for coordination of care between Primary Care Physicians and specialty providers occurs.</p>	<p>Please see Deficiency 2.2 – Attachment A. For the process description, please see “Process Change” section below; Update CCS training materials to inform Delegates that a process must be developed within the organization which reflects coordination of care between primary care physicians and specialty providers; currently in “draft” format. Please see Deficiency 2.2 – Attachment B. Trainings will be mandatory for all Delegates. IEHP will begin Delegate training June 1, 2015. IEHP will conduct Delegate training annually thereafter. IEHP will complete at least two (2) Delegate training sessions per month; and Development of a CCS training schedule for Delegates with an anticipated completion date of June 1, 2015.</p> <p>Process Change: On a monthly basis CCS staff will review all cases referred to the County CCS agencies during the previous month to identify Member who have been determined to be eligible for CCS benefits. See Deficiency 2.2 – Attachment C. When Members are determined as newly eligible for CCS benefits and identified as having complex care needs Care Management staff will complete the following: Contact the Member’s PCP office and inform provider of Member’s CCS eligibility diagnosis and</p>	<p>Members are turning 21 years of age and will no longer qualify for CCS. This was not a new process, but was not reflected clearly in the policy. Policy is marked with “DRAFT” watermark as internal policies have not yet completed the IEHP annual review process. See Deficiency 2.2 – Attachment D. All updates to policies have been highlighted.</p> <p>Training: Staff training regarding CCS care coordination process was completed on November 21, 2014. The job aid titled “CCS Care Management” was reviewed and distributed to staff during the training session. See Deficiency 2.2 – Attachment A.</p>	<p>Eligible Members Commencement Date.</p> <p>6/1/2015 – CCS Training Schedule to be developed and Delegate Training to commence.</p>	<p>This deficiency is deemed open.</p> <p>Please see DHCS Medical Audit CAP Follow-Up Response document.</p> <p>5/21/2015 – Documents submitted by IEHP was reviewed.</p> <p>This deficiency is provisionally closed.</p> <p>Follow up will be conducted to ensure health plan action is taken and verification will be conducted during the next Medical Performance Audit process.</p>

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	<p>services/specialty providers authorized; copies of CCS Service Authorization Request(s) (SARs) will be made available to providers as appropriate and/or as requested; Contact the parent/guardian and provide details regarding CCS eligibility, services/specialty providers authorized, and how to utilize CCS and IEHP benefits; copies of CCS Service Authorization Request(s) (SARs) will be made available to parents as appropriate and/or as requested; and Members with CCS eligibility who have been identified to have complex medical needs and could benefit from routine Care Management interventions/contact will be referred to the appropriate Care Management team for assessment and possible enrollment into a care management program which supports the Member's health needs.</p> <p>Quality Assurance: To ensure on-going monitoring of CCS Member care coordination and identification of staff re-education, a file review process has been established. A file review tool has been developed and a random sample of five nurse files will be reviewed on a monthly basis. Up to date, all files reviewed have presented with a passing score and no corrective action plans (CAP) have been warranted.</p>			

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<p>2.3 – EARLY INTERVENTION SERVICES /</p> <p>DEVELOPMENTAL DISABILITIES Plan did not provide documentation for coordination of care between PCPs (Primary Care Physicians) and specialists for all Early Intervention/Developmental Disabilities (EI/DD) Members.</p> <p>Recommendation: Develop a monitoring system to ensure that all Early Intervention/Developmental Disabilities (EI/DD) eligible Members receive primary care services and there is coordination of care that occurs between Primary Care Provider (PCP) and EI/DD specialists.</p>	<p>Remediation Activity: IEHP has implemented the following remediation activities:</p> <p>Implementation of process to monitor EI/DD eligible Members for coordination of care between primary care physicians and EI/DD specialty providers;</p> <p>Update IRC (EI/DD) training materials to inform Delegates of new data available on provider portal which indicates Members who have current IRC eligibility and are under the age of 36 months. Trainings will be mandatory for all Delegates. IEHP will begin Delegate training June 1, 2015. IEHP will conduct Delegate training annually thereafter. IEHP will complete at least two (2) Delegate training sessions per month;</p> <p>Update IRC (EI/DD) training materials to inform Delegates that a process must be developed within their organization which reflect coordination of care between primary care physicians and specialty care providers; currently in “draft” format. See Deficiency 2.3 – Attachment A. Trainings will be mandatory for all Delegates. IEHP will begin Delegate training June 1, 2015.</p>	<p>Policy & Procedures: Policy MED_CM 7.c Early Start Services and Referrals has been updated to reflect the care coordination monitoring and communication process change noted above. The policy is marked with “DRAFT” watermark as internal policies have not yet completed the IEHP annual review process. See Deficiency 2.3 – Attachment B. All updates to policies have been highlighted.</p> <p>Training: Staff training and job aid development regarding care coordination process is pending. The IRC EI/DD report has a proposed launch date of March 1, 2015. Once the report has been generated and information posted to the provider portal, CM staff will receive training</p>	<p>1/2015 – IRC EI/DD report launch date.</p> <p>5/1/2015 – A file review tool for Members with IRC EI/DD eligibility will be developed.</p> <p>5/1/2015 – A QA process for reviewing Member files will be established. A random selection of five (5) Member files per nurse will be selected for review by the 20th of each month.</p> <p>6/1/2015 – Delegate Training Schedule to be developed and Delegate Training to commence.</p>	<p>3/9/2015 – Attachments A and B submitted by IEHP were reviewed. Please provide a copy of the monthly</p> <p>Members by Delegate report and the File Review Tool.</p> <p>This deficiency is deemed open. Please see DHCS Medical Audit CAP Follow-Up Response document.</p> <p>5/21/2015 – Documents submitted by IEHP was reviewed.</p> <p>This deficiency is provisionally closed.</p> <p>Follow up will be conducted to ensure health plan action is taken and verification will be conducted during the next Medical Performance Audit process.</p>

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	<p>IEHP will conduct Delegate training annually thereafter. IEHP will complete at least two (2) Delegate training sessions per month;</p> <p>Development of an IRC training schedule for Delegates with an anticipated completion date of June 1, 2015.</p> <p>Process Change: A report listing all Members by Delegate who have current Inland Regional Center eligibility and are under the age of 36 months will be generated and distributed to the Care Management Team on a monthly basis with a tentative start date of March 6, 2015. The report will be posted to the IEHP Provider Portal on a monthly basis with a tentative start date of March 6, 2015 as a new Inland Regional Center roster to communicate and coordinate services with Members' primary care providers to ensure continuity of care between primary care physicians and specialists.</p> <p>Quality Assurance: To ensure on-going monitoring of EI/DD Member care coordination and identification of staff re-education, a file review process will be established. A file review tool for Members with IRC EI/DD eligibility will be developed by May 1, 2015. A QA process for reviewing</p>	<p>regarding the care coordination process and dissemination of the reporting data.</p>		

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	Member files will be established by May 1, 2015. A random selection of five (5) Member files per nurse will be selected for review by the 20th of each month.			
<p>2.4 – INITIAL HEALTH ASSESSMENT The plan did not complete the Initial Health Assessments (IHA) within required timeframes for some of the members.</p> <p>Recommendation: Ensure that Providers complete the Individual Health Assessment for all new Members within the timelines stipulated in the Contract.</p>				No Corrective Action is required for this item. Considering that contract requirements have been changed to require that IHA to be completed within 120 days for all members.
4. Members' Rights				
<p>4.3- CONFIDENTIALITY RIGHTS</p> <p>4.3.1 - The Plan failed to notify the Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) Contract Manager and the DHCS Information Security Officer of HIPAA</p>	<p>Remediation Activity: In September 2014, the Compliance Department formed the Special Investigations Unit (SIU) that is made up of a Manager, Business Analyst and a Specialist. The unit is responsible for taking in all allegations of Fraud Waste and Abuse (FWA), privacy issues and issues of non-compliance. An increased focus has been made on reporting to the DHCS Privacy Office, the plan's Contract Manager and DHCS</p>	<p>Policy & Procedures: The following policies, procedures and job aids were revised or created in response to this audit finding: PRO_CMP 04a – HIPAA Program Description (NCQA) PRO_CMP 04n – Notification of Privacy Breach, Risk Assessment</p>	<p>9/2014 – Special Investigations Unit was formed.</p> <p>1/16/2015 – Compliance Department Team</p> <p>Training completed. By 2nd Quarter 2015, the SIU</p>	<p>3/9/2015 – Attachments A, B, C, D, E, F, and G submitted by IEHP were reviewed. Please provide a copy of team training sign-up sheet. This deficiency is deemed open. Please see DHCS Medical Audit CAP Follow-Up Response document.</p> <p>5/21/2015 – Documents submitted by IEHP was reviewed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
<p>mandated by contract.</p> <p>Recommendation: Ensure that all the actual and suspected breaches are reported to the Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) Contract Manger, the DHCS Privacy Officer, and the DHCS Information Security Officer.</p>	<p>Information Security Officer when reporting actual or suspected privacy breaches.</p> <p>To accomplish this, all Compliance Department staff was trained on January 16, 2015 on the contractual agreement to notify the DHCS Privacy Office, Contract Manager and DHCS Information Security Officer. A reporting workflow was created to clearly delineate the agencies/offices that need to be notified when reporting certain case types. The Notification of Privacy Breach, Risk Assessment and Reporting policy was reviewed and revised to ensure that the plan's contractual obligations were accurately defined.</p> <p>Process Change: The SIU Manager is responsible for all areas of investigations which have created greater accountability in ensuring all cases are reported to the appropriate DHCS offices.</p> <p>Quality Assurance: Auditing and Monitoring Unit will implement an auditing tool and audit cycle (at least quarterly) for the SIU Investigation Cases. Their audit will validate that the appropriate DHCS offices are notified when an actual or suspected breach has been identified that involves Medi-Cal beneficiaries.</p>	<p>and Reporting PRO_CMP 01E – Special Investigations Unit Regulatory Reporting Workflow New Investigations Case Summary Monthly SIU Case Metrics Report See Deficiency 4.3.1 – Attachments A – F. All updates to policies have been highlighted.</p> <p>Training: All staff in the Compliance Department was trained on the new policy changes, SIU investigation process and reporting requirements/timeframes on January 16, 2015. See Deficiency 4.3.1 – Attachment G.</p>	<p>Investigations Cases Audit will be fully implemented.</p>	<p>This deficiency is provisionally closed.</p> <p>Follow up will be conducted to ensure health plan action is taken and verification will be conducted during the next Medical Performance Audit process.</p>

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	<p>This process and audit schedule will be fully implemented by Quarter 2, 2015. All audit results will be reported to the Audit Subcommittee.</p>			
<p>4.3.2 - The Plan failed to report some of the suspected breaches within the required time frame, as mandated by the contract.</p> <p>Recommendation: Ensure that the initial notification of PHI breach is submitted to DHCS personnel within the required time frame as stipulated in the DHCS Contract</p>	<p>Remediation Activity: In September 2014, the Compliance Department formed the Special Investigations Unit (SIU) that is made up of a Manager, Business Analyst and a Specialist. The unit is responsible for taking in all allegations of FWA, privacy issues and issues of non-compliance. An increased focus has been made on reporting to the DHCS Privacy Office, the plan's Contract Manager and DHCS Information Security Officer within the timeframes stipulated in the contract that the plan has with DHCS. To accomplish this, all Compliance Department staff was trained on January 16, 2015 on the contractual agreement to notify the DHCS Privacy Office, Contract Manager and DHCS Information Security Officer within twenty-four (24) hours of detecting an actual or suspected privacy breach and seventy-two hours (72) to file an initial report. A reporting workflow was created to clearly delineate the timeframes that the plans are required to meet as part of the notification process. The Notification of Privacy Breach, Risk Assessment and Reporting policy was reviewed and revised to ensure that the plan's</p>	<p>Policy & Procedures: The following policies, procedures and job aids were revised or created in response to this audit finding: PRO_CMP 04a – HIPAA Program Description (NCQA) PRO_CMP 04n – Notification of Privacy Breach, Risk Assessment and Reporting PRO_CMP 01E – Special Investigations Unit Regulatory Reporting Workflow New Investigations Case Summary Monthly SIU Case Metrics Report See Deficiency 4.3.2 – Attachments A – F. All updates to policies have been highlighted.</p> <p>Training: All staff in the Compliance Department was trained on the new policy changes,</p>	<p>9/2014 – Special Investigations Unit was formed.</p> <p>1/16/2015 – Compliance Department Team Training completed.</p> <p>By 2nd Quarter 2015, the SIU Investigations Cases Audit will be fully implemented.</p>	<p>3/9/2015 – Attachments A, B, C, D, E, F, and G submitted by IEHP were reviewed. Please provide a copy of team training sign-up sheet.</p> <p>This deficiency is deemed open. Please see DHCS Medical Audit CAP Follow-Up Response document.</p> <p>5/21/2015 – Documents submitted by IEHP was reviewed.</p> <p>This deficiency is provisionally closed.</p> <p>Follow up will be conducted to ensure health plan action is taken and verification will be conducted during the next Medical Performance Audit process.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>contractual obligations were accurately defined.</p> <p>Process Change: The SIU Manager is responsible for all areas of investigations which have created greater accountability for ensuring all cases are reported to the appropriate DHCS offices.</p> <p>Quality Assurance: Auditing and Monitoring Unit will implement an auditing tool and audit cycle (at least quarterly) for the SIU Investigation Cases. Their audit will validate that the appropriate DHCS offices are notified within the mandated timeframes when an actual or suspected breach has been identified that involves Medi-Cal beneficiaries. This process and audit schedule will be fully implemented by Quarter 2, 2015. All audit results will be reported to the Audit Subcommittee.</p>	<p>SIU investigation process and reporting requirements/timeframes on January 16, 2015. See Deficiency 4.3.2 – Attachment G. All updates to policies have been highlighted.</p>		
5. Quality Management				
<p>5.5 – MEDICAL RECORDS</p> <p>The verification studies of medical records from the Plan's provider locations indicate that the providers failed to maintain complete and accurate</p>	<p>Remediation Activity: IEHP will continue to conduct Facility Site Reviews and Medical Records Review (MRR) as outlined in Provider Manual Policy and Procedure MC 7A Medical Records Requirements: PCP and IPA Medical Record Requirements. In addition, IEHP will annually report the results of the MRR audits conducted.</p>	<p>Policy & Procedures: Please see Deficiency 5.5 – Attachment B, Provider Manual Policy and Procedure 7.A Medical Records Requirements: PCP and IPA Medical Record Requirements. All updates to policies have</p>	<p>IEHP will annually report the results of the MRR audits conducted. Rates will be reviewed and discussed at IEHP's Quality Improvement Committee.</p>	<p>3/9/2015 – Attachments A and B submitted by IEHP were reviewed.</p> <p>This deficiency is deemed closed.</p>

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<p>medical records for all Members.</p> <p>Recommendation: Ensure that a complete medical record is maintained for each Member and continue to monitor provider compliance with Facility Site Reviews including medical record reviews</p>	<p>Rates will be reviewed and discussed at IEHP's Quality Improvement Committee.</p> <p>Process Change: A new annual MRR Study was developed for ongoing monitoring of the MRR audit performance. See Deficiency 5.5 – Attachment A, Annual MRR Study.</p> <p>Quality Assurance: QA will consist of Medical Record Review at the time of the Site Audit Review every three (3) years or on an interim basis at eighteen (18) months if a provider was placed on a Corrective Action Plan. The plan will ensure that provider's medical records are monitored per policy. The Director of Quality Management and Quality Management Nurse Manager will monitor oversight activities and ensure activities are consistent with Quality Management related policies & procedures.</p>	<p>been highlighted.</p> <p>Training: N/A</p>		

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<p>5.6 – INFORMED</p> <p>CONSENT In some of Member’s medical records the Informed Consent (IC) documentation was missing.</p> <p>Recommendation: Develop a system to monitor for compliance in the completion of Informed Consent forms and ensure that all IC forms are completed and documented adequately in member’s medical records.</p>	<p>Remediation Activity:</p> <p>1) System Configuration Ensure IEHP’s Diamond claims system prompts an examiner to verify receipt of a PM-330 form. During claim adjudication, the Diamond system is properly configured to display hold code “Consent Form must be attached” for professional or hospital claims containing sterilization diagnosis or surgery coding.</p> <p>2) Claims Examiner Training Ensure all claims processing and auditing staff are aware of DHCS PM-330 requirements for Family Planning claims. On December 12, 2014, Claims Staff were re-educated on the PM-330 requirements. On December 12, 2014, Desktop Reference Guides for entitled elective sterilizations were redistributed. PM-330 requirements are incorporated with new Claims Examiner training courses.</p> <p>3) Quality Control Pre-Payment Audit Developed. On November 1, 2014, IEHP strengthened its existing sterilization claims focus audit and now reviews paid and denied Family Planning claims for appropriateness. This audit is generated on a daily basis and places 100% of</p>	<p>Policy & Procedures:</p> <p>Policy P-12 Family Planning updates were not required as DHCS approved IEHP’s claim policy, (attached for record is the P-12 Family Planning Services policy). See Deficiency 5.6 – Attachment A. Medi-Cal Provider Manual Policies MC 10F Sterilization Services under Procedure B.3.a and Medi-Cal Provider Manual MC Policy 7.C Informed Consent under Procedure D and F have been updated. All updates to policies have been highlighted. See Deficiency 5.6 – Attachments B and C.</p> <p>Training: Please see #2 Claims Examiner Training above. IPA network was notified in October 2014 during quarterly IPA Meeting regarding the requirement for payment of claims PM 330 Sterilization Consent form must be included with</p>	<p>10/1/2014 – Developed Post-Payment Audit for Sterilization Claims to take place every month. October 2014 – IPA Network notifications were made on requirement for payment of claims and submission of PM-330 Forms.</p> <p>11/1/2014 – Strengthened existing sterilization claims focus audit and began reviews on paid and denied Family Planning claims.</p> <p>12/12/2014 – Claims Team Training on PM-330 requirements was conducted and Reference Guides were redistributed.</p>	<p>3/9/2015 – Attachments A and B submitted by IEHP were reviewed.</p> <p>This deficiency is deemed closed.</p>

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	<p>identified claims in an audit database for claim auditor review. If an auditor detects a claim that is paid and no corresponding PM-330 form is located, an error will be assigned to the Claims Examiner and the claim will be placed in a hold status awaiting correction.</p> <p>4) Quality Control Post-Payment Audit Developed. On October 1, 2014, IEHP developed a post-payment audit for sterilization claims (based on surgical procedure code criteria). This audit is generated on a monthly basis. 100% of sterilization claims are reviewed by designated staff to ensure a PM-330 form is on record. If the reviewer detects a paid claim with no corresponding PM-330 form, is located an error will be assigned to the Claims Examiner and an overpayment recovery request to providers of service will be issued.</p> <p>Process Change: The focused pre-pay and post-pay audits were added to the claims IEHP QA process. Provider Manual policies MC 10.F Sterilization Services and MC 7.C Informed Consent now specifically denote that a PM-330 Consent Form must be included with any claims submitted in order for contracted and</p>	<p>claims for payment.</p>		

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	<p>out of network family planning practitioners to be reimbursed for all covered contraceptive methods, including sterilization services.</p> <p>Quality Assurance: See "Quality Controls" sections 3-4 above.</p>			
6. Administrative and Organizational Capacity				
<p>6.5 - FRAUD AND ABUSE The Plan did not ensure that all potential fraud, waste, and abuse cases were reported to DHCS within the time frames required by the contract.</p> <p>Recommendation: Develop a monitoring system to ensure that all suspected fraud and abuse cases are reported to Department of Health Care Services within the 10 working day timeframe.</p>	<p>Remediation Activity: In September 2014, the Compliance Department formed the Special Investigations Unit (SIU) that is made up of a Manager, Business Analyst and a Specialist. The unit is responsible for taking in all allegations of Fraud, Waste and Abuse (FWA), privacy issues and issues of non-compliance. An increased focus has been made on concluding investigations in a reasonable time after the activity is discovered and ensuring that reportable cases are sent to the DHCS PIU within the required timeframes. To accomplish this, the SIU has implemented new data elements in its case tracking log to show days elapsed from the date a case was opened as well as a best practice closure date. Additionally, the new Investigations Case Summary form includes sections for specifying the initial inquiry date and what actions were taken as part of the initial inquiry. The</p>	<p>Policy & Procedures: The following policies, procedures and job aids were revised or created in response to this audit finding: PRO_CMP 03A – FWA Program PRO_CMP 03b- FWA Reporting Procedures PRO_CMP 01E – Special Investigations Unit Regulatory Reporting Workflow New Investigations Case Summary Monthly SIU Case Metrics Report See Deficiency 6.5 – Attachments A – F. All updates to policies have been highlighted.</p> <p>Training: All staff in the Compliance</p>	<p>9/2014 – Special Investigations Unit was formed.</p> <p>12/2014 – SIU Manager has implemented a monthly SIU Case Metrics reporting process to the Compliance Officer to increase communications and transparency of case status.</p> <p>1/16/2015 – Compliance Department Team Training completed. By 2nd Quarter 2015, the SIU</p>	<p>3/9/2015 – Attachments A and B, C, D, E, F, and G submitted by IEHP were reviewed.</p> <p>This deficiency is deemed closed.</p>

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>FWA Program, FWA Reporting Procedures and the Special Investigations Unit Policy specify case closure and reporting timeframes. All staff in the Compliance Department were trained on the new policy changes, SIU investigation process and reporting requirements/timeframes on January 16, 2015.</p> <p>Additionally, the creation of the new SIU group included a restructuring of the previous FWA and Privacy group by placing the SIU Manager over all areas of investigation and creating greater accountability for ensuring all cases are closed according to regulatory requirements. Beginning December 2014, the SIU Manager has implemented a monthly SIU Case Metrics reporting process to the Compliance Officer to increase communications and transparency of case status.</p> <p>Process Change: New data elements were added to the SIU case tracking log to show days elapsed from the date a case was opened as well as a best practice closure date which mirror the ten (10) working days that IEHP is contractually obligated to report by. The SIU Manager has been placed over all areas of investigations which have created</p>	<p>Department was trained on the new policy changes, SIU investigation process and reporting requirements/timeframes on January 16, 2015. See Deficiency 6.5 – Attachment G. All updates to policies have been highlighted.</p>	<p>Investigations Cases Audit will be fully implemented.</p>	

Deficiency Number and Finding	Action Taken	Implementation Documentation	Completion/ Expected Completion Date	DHCS Comments
	<p>greater accountability for ensuring all cases are closed according to the plan's contractual agreements with DHCS.</p> <p>Quality Assurance: Auditing and Monitoring Unit will implement an auditing tool and audit cycle (at least quarterly) for the SIU Investigation Cases. Their audit will validate initial inquiry dates, closure dates, reporting dates and closure/reporting timeliness. This process and audit schedule will be fully implemented by Quarter 2, 2015. All audit results will be reported to the Audit Subcommittee.</p>			
7. STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS				
<p>7 – Abortion The Plan's Provider policy and procedure Manual (MC_09E) did not include language that Members have the right to access sensitive services through a contracted or non-contracted qualified provider. The policy states that sensitive services can be obtained</p> <p>through any qualified practitioner contracted</p>	<p>Remediation Activity: Update the language in the Provider policy and procedure manual, MC 9E Access to Sensitive Services to include the contractual stipulation that Members have the right to access sensitive services through a contracted or non-contracted qualified provider.</p> <p>Process Change: N/A</p> <p>Quality Assurance: N/A</p>	<p>Policy & Procedures: Please see Deficiency 7 – Attachment A for the updated Medi-Cal Provider Manual Policy MC 9E Access to Sensitive Services. All updates to policies have been highlighted.</p> <p>Training: N/A</p>	<p>7/1/2014 – Updates to PnP completed.</p>	<p>3/9/2015 – Attachments A submitted by IEHP were reviewed.</p> <p>This deficiency is deemed closed.</p>

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<p>with the Member's IPA (MC_09.3).</p> <p><u>Recommendation:</u> Update the language in the Provider policy and procedure manual, Access to Sensitive Services (MC_09E) to include the contractual stipulation that Members have the right to access sensitive services through a contracted or non-contracted qualified provider</p>				

Submitted by:

Date: May 20, 2015

**Dr. Bradley Gilbert,
Title: Chief Executive Officer**