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

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December 1, 2022

Erika Oduro, Regulatory Affairs Manager
Inland Empire Health Plan
10801 6th St., Ste. 120
P.O. Box 1800
Rancho Cucamonga, CA 91729

RE: Department of Health Care Services Medical Audit

Dear Ms. Oduro,

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 September 27, 2021 through October 8, 2021. The audit covered the period of October 1, 2019 through July 31, 2021.

On November 30, 2022, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on February 18, 2022.

All items have been evaluated and DHCS accepts the MCP's submitted CAP. The CAP is hereby closed. Overall effectiveness of the CAP will continue to be assessed, as well as to what extent the MCP has operationalized proposed corrective actions in the subsequent audit. The enclosed documents will serve as DHCS' final response to the MCP's CAP. Closure of this CAP does not halt any other processes in place between DHCS and the MCP regarding the deficiencies in the audit report or elsewhere, nor does it preclude the DHCS from taking additional actions it deems necessary regarding these deficiencies.

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

If you have any questions, feel free to contact me at (916) 345-7942 or Diana O'Neal at (916) 345-8668.

Sincerely,

[Signature on file]

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

Enclosures: Attachment A (CAP Response Form)

cc: Lyubov Poonka, Chief
CAP Compliance Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

Diana O'Neal, Lead Analyst
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Rebeca Cabiedes, Contract Manager
Medi-Cal Managed Care Division
Department of Health Care Services

ATTACHMENT A
Corrective Action Plan Response Form

Plan: Inland Empire Health Plan

Review Period: 10/01/2019 – 07/31/2021

Audit Type: Medical Audit and State Supported Services

On-site Review: 09/27/2021 – 10/08/2021

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MCPs are required to provide a CAP and respond to all documented deficiencies within 30 calendar days, unless an alternative timeframe is indicated in the CAP Request letter. MCPs are required to submit the CAP in word format that will reduce turnaround time for DHCS to complete its review. According to ADA requirement, the document should be at least 12 pt.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. The MCP shall directly address each deficiency component by completing the following columns provided for MCP response: 2. Action Taken, 3. Implementation Documentation, and 4. Completion/Expected Completion Date. The MCP will be required to include project timeline with milestones in a separate document for each finding. Supporting documentation should accompany each Action Taken. For policies and other documentation that have been revised, please highlight the new relevant text. For deficiencies that require short-term corrective action, implementation should be completed within 30 calendar days. For deficiencies that may be reasonably determined to require long-term corrective action for a period longer than 30 days to completely remedy or operationalize, the MCP is to indicate that it has initiated remedial action and is on the way towards achieving an acceptable level of compliance. In those instances, the MCP will be required in addition to the above steps, to include the date when full compliance will be achieved. **Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval, as applicable in accordance with existing requirements.**

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

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1. Utilization Management				
1.2.1 Prior Authorization Requirements Exemption for Preventive Services The Plan applied prior authorizations to preventative services.	1. **Process Change** - The Plan and its Delegates will notify Providers and Members that preventive services do not require prior authorization. Notification will indicate: • Services requested do not require prior authorization; • Claim for the requested services will be paid; and • The Plan reserves the right to review these claims to ensure that services are appropriate per USPSTF A and B Recommendations, ACIP or Bright Futures/AAP. In the event that a Provider refuses to render the service without an authorization in place, the Plan will authorize services for tracking purposes so as not to delay the Member's	The Plan will provide the following documentation: • Process documentation – Provider/ Member Notification • Process documentation – Retrospective claims review • Communication materials	**Short-Term:** • **05/01/22** – On or before this date, the Plan will inform IPAs of process requirements and oversight plan **Long-Term:** • **07/01/22** – On or before this date, the Plan and its Delegates will begin notifying Providers and Members that preventive services do not require prior authorization • **09/30/22** - On or before this date, the Plan will begin	The following documentation supports the MCP's efforts to correct this finding: **Policy** - Policy MC_25E1 Delegation and Oversight Revision Date 1/1/22 require delegates to maintain a list of services that require prior authorization or a list of services that do not require prior authorization. Services that don't require prior authorization in this policy include preventive services. - Policy MC_14D Utilization Management Pre-Service Referral Authorization Process revision date 1/1/22 specifies that preventive services do not require prior authorization and may be self-referred by the member. **Monitoring** - Email communication from 8/4/22 clarified the MCP's monitoring plans. The MCP will apply its existing monthly UM delegation oversight audit to ensure sustained compliance with the requirements. Medi-Cal IPAs will continue to be required to submit to the MCP a "Referral Universe" containing details regarding the approval, partial approval, and denial of services, on a monthly basis. The MCP will review these submissions as part of a monthly audit process designed to monitor the performance of its IPAs. The MCP will review these files for evidence that approvals are being applied to services that are considered preventive. In the event that Medi-Cal IPAs are found to be improperly requiring prior authorization for preventive services,

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	care. 2. **Training and Communication** • IPAs will be informed of process requirements and oversight plan, as described above. • Providers and their staff members will be notified that, per IEHP policy, preventive services are not subject to prior authorization and should instead be submitted directly to Claims for payment. Communication will be provided through the IEHP Provider Manual of Policies and Procedures, Provider portal on IEHP's public website, Provider trainings, blastfax, and targeted outreach, as described above. • IEHP Members will continue to be informed that preventive services		incorporating these process requirements into the monthly oversight audit**.** • **09/30/22** – On or before this date, the Plan will begin quarterly retrospective claims review.	appropriate interventions will be taken to prevent further non-compliance, including but not limited to the issuance of corrective action requests. - Clarification of delegation monitoring for preventive services states The MCP will apply its existing monthly UM delegation oversight audit to ensure sustained compliance with the requirements. Medi-Cal IPAs will continue to be required to submit to the MCP a "Referral Universe" containing details regarding the approval, partial approval, and denial of services, on a monthly basis. The MCP will review these submissions as part of a monthly audit process designed to monitor the performance of its IPAs. The Plan will review these files for evidence that approvals are being applied to services that are considered preventive. In the event that Medi-Cal IPAs are found to be improperly requiring prior authorization for preventive services, appropriate interventions will be taken to prevent further non-compliance, including but not limited to the issuance of corrective action requests. - ACMG Authorizations for Preventive Services Summary demonstrates the MCP monitors its delegates to ensure prior authorizations are not required for preventive services the summary informed the IPA that preventive services were approved although no prior authorization was required. IPA was informed all authorization request for preventive services must be cancelled. **Training/Implementation** - All Medi-Cal IPA Notice, dated 6/23/22, and Medi-Cal Providers Direct Notice informs IPAs and providers that the MCP maintains a list

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	do not require prior authorization through the IEHP Member Handbook, IEHP website, Member newsletters, and targeted outreach, as described above. • IEHP Team Members will be trained on the Provider and Member notification process described above through internal training efforts. 3. **Oversight** • IEHP UM Department will begin to retrospectively review claims and associated clinical data on a quarterly basis to ensure preventive services are not processed through the prior authorization process. • IEHP UM Delegation will incorporate these			of services that do not require prior authorization including preventive services. The notice directs providers to the DHCS Medi-Cal Provider Manual for list of services which DHCS considers to be preventive. - MC_09G Access Standards Cancer Treatment Services revision date 1/1/22 was updated to specify that the MCP doesn't require prior authorization for preventive services including cancer screenings that are United States Preventive Services Task Force (USPSTF) Part A and B recommendations. Draft Member Newsletter for 8/17/22, Member Handbook and Public Website educates members that preventive services do not require prior authorization. Provider Training Guide excerpt educates providers that preventive services can be self-referred by members. Public Website Provider Portal educates providers that preventive services do not require prior authorization. No Prior Authorization Required template was sent to inform members that they don't need a referral for the particular preventive service that was requested. **The Corrective Action Plan for Finding 1.2.1 is accepted.**

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	process requirements into the monthly oversight audit.			
1.3.1 Appeals System Oversight The Plan did not document the periodic review and evaluation of their appeals system. The Plan did not have documentation of the review done by the governing body, public policy body and officer, or designee.	1. **Review of Written Log** – The Plan will present to the Governing Board and the Public Policy Participation Committee (PPPC) its Grievance & Appeals (G&A) written log, along with summary and trends identified. Appropriate time will be allotted to allow for meaningful review and discussion of information, including but not limited to the identification of issues, and quality improvement opportunities. The Plan will leverage the meeting minutes and/or working papers to document the review and evaluation of the G&A written log. 2. **Oversight** – This activity will be added to the QM/QI Workplan to ensure that the written log is presented to the Governing Board and	The Plan will provide the following documentation: • Revised policies and procedures that describe review of the written log by the Governing Board & PPPC • Updated QM/QI Workplan • Governing Board & PPPC Meeting Minutes and/or Working Papers • Sample report and written log presented to the Governing Board & PPPC	**Short-Term:** • **04/11/22** – On or before this date, review G&A written log for Medi-Cal with Governing Board **Long-Term:** • **06/15/22** – On or before this date, review G&A written log for Medi-Cal and CMC with PPPC	The following documentation supports the MCP's efforts to correct this finding: **Implementation** Governing Board meeting report/meeting minutes (4/11/22) that demonstrates the review and evaluation of the written appeals log; including the following: Grievance and Appeals Annual Study • Review case volume and identify trends and assess areas of opportunity to improve member satisfaction • Grievance and appeals are grouped by category: Access, attitude/service, benefits, billing, compliance, enrollment/disenrollment, quality of care, quality of provider site. Outlines next steps: ○ Identify transportation trends/address issues ○ Establish escalation protocol for transportation related issues ○ Transportation vendor on CAP ○ Establish escalation process for PCPs with identified trends, address quality of care issues Public Policy Participation Committee Report

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	PPPC timely and consistently.			Grievance and Appeals Process report used to enhance member experience and identify improvement opportunities. Report includes the following: ○ Case volume 2021 ○ Top five G&A categories 1. Grievance improvements 2. Provider change process within the member portal 3. Online grievance forms 4. Transportation broker was placed on a CAP – late drivers/missed appointments, specifically related to dialysis patients. 5. Updated call center hold messages Appeals Improvements ○ Improve consistence in nurse recommendations and medical director reviews ○ Ensure appropriate application of review of grievance and appeal logs ○ Review overturned appeals, identify trends and promote discussion for remediation Public Policy Participation Committee (PPPC) meeting minutes ○ Plan provided documented evidence of the review of grievance and appeal logs ○ Discussion included audit findings, decline to file, exempt, and standard grievances and appeals. ○ Top categories and potential root cause/impact – pandemic, staffing, included member participation/discussion regarding decline to file situations.

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				2022-2024 Quality Management/Quality Improvement Work Plan Provide updates from the Grievance and Appeals Review Committee. The purpose of the committee is to provide direction necessary to monitor and evaluate Grievance and Appeals related data and to provide guidance in identifying trends and develop action plans to resolve Grievance and Appeal trends and focus improvement activities throughout IEHP. Grievance and Appeals Study - The purpose of this study is to assess Member experience with Inland Empire Health Plan (IEHP) services by evaluating grievances and appeals trends. The Grievance and Appeal (G&A) Study is conducted annually and reviews case volume and rates to identify trends and assess areas of opportunity to improve overall Member satisfaction. **The Corrective Action Plan for Finding 1.3.1 is accepted.**
1.3.2 Decision-Maker & Written Notification Letters The Plan did not identify the name of the decision maker within the written appeal notification letter.	1. **Appeal Resolution and Downgrade Letters** – The Plan will configure DHCS-approved letter templates in its medical management system to pull from the Appeal Decision-Maker field. 2. **Oversight** – The Plan will continue its daily review of completed appeals to	The Plan will provide the following documentation: • Updated Appeal Resolution Letter Templates • Sample Resolution and	**Short-Term:** • N/A **Long-Term:** • **06/30/22** – On or before this date, implement the configuration changes in the medical	The following documentation supports the MCP's efforts to correct this finding: **Implementation** - Examples of Notice of Appeal Resolution Letters were provided that show the decision maker's name is included.

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	ensure, among other elements, the accurate documentation of the Appeal Decision-Maker in the medical management system, as well as on resolution and downgrade letters.	Downgrade letters (PHI redacted) • Process Documentation – Appeal resolution • Process Documentation – Daily QA	management system	- DTR-094-APP-Medical Appeals Process demonstrates the MPC has configured its system to pull from the appeal decision maker field to ensure its inclusion in appeal resolution letters. **Monitoring** - G&A QA Plan demonstrates the MCP monitors appeal resolution letters and expedited/downgrade appeal to ensure the decision maker's name is included. **The Corrective Action Plan for Finding 1.3.2 is accepted.**
3. Access and Availability of Care				
3.8.1 Physician Certification Statement (PCS) Form The Plan did not ensure the required PCS forms were utilized for transportation services provided, nor did the Plan ensure PCS forms contained all required components.	1. **PCS Form Elements** – The Plan will revise the online PCS form on the secure IEHP Provider portal to match the DHCS-approved PCS form by including the Date of Service, which had been inadvertently omitted. 2. **Obtaining PCS Form** – The Plan will begin conducting telephonic outreach to the Provider to ensure a completed PCS form is on file for NEMT requests. 3. **Training & Communication** • Providers will be	The Plan will provide the following documentation: • Screenshot of updated online PCS form • Process Documentation – NEMT Requests • Onboarding Training - Transportation • Revised Policies and Procedures	**Short-Term**: • **05/01/22** – On or before this date, send out communication to Providers reminding them of the requirement to submit PCS forms • **05/16/22** – On or before this date, deploy the revised online PCS form with	The following documentation supports the MCP's efforts to correct this finding: **Policies & Procedure** The Plan updated P&Ps to address the gap that contributed to the deficiency: • Procedure "Physician Certification Form Quality Assurance Guide" demonstrates the Plan has a process to ensure Physician Certification Statement (PCS) Forms are captured for members requiring NEMT, being reviewed monthly by the 10th of each month. • P&P "MC_09C NEMT & NMT Services" demonstrates the following:

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	reminded that a completed PCS form must be on file to authorize NEMT requests. Communication will be completed through blastfax, joint operations meetings with IPAs, and targeted outreach. • The Plan's Transportation Team will be trained on the telephonic outreach process. Training will also be integrated into the onboarding process for new hires. 4. **Oversight** – The Plan will retrospectively review a random sample of NEMT requests to ensure that a completed PCS form was received, and additional outreach was conducted.	• Training and communication materials	all required elements. **Long-Term:** • **06/01/22 –** On or before this date, begin conducting outreach to Providers to obtain missing PCS form prior to authorizing services. • **07/01/22 –** On or before this date, implement retrospective QA review of PCS requirement and outreach	○ The policy has been amended to include that the Plan utilizes a PCS form that has been approved by DHCS that includes all required components to arrange for NEMT services. ○ The PCS form must be completed before NEMT can be provided. ○ The Plan ensures that a copy of the PCS form is on file for all members & that all fields will be filled out by the provider. **Implementation/Oversight & Monitoring** The Plan identified, developed and deployed an internal auditing process to continuously self-monitor to detect and prevent future non-compliance: • Procedure "Physician Certification Form Quality Assurance Guide" demonstrates that the Plan randomly samples 5% of daily coordination from the monthly trip log & reviews for; ○ Date trip received; ○ Date trip coordination was completed; ○ Was PCS form collected date of coordination; ○ Provider outreach completed; & ○ If PCS was received after outreach. • P&P "MC_09C NEMT & NMT Services" demonstrates the Plan will be tracking that the transportation broker & providers are complying with all requirements set forth in APL 22-008, ensuring monitoring activities are performed no less than quarterly, including but not limited to:

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				○ Non-modification of the level of transportation service outlined in the PCS form; ○ Providing door-to-door assistance for NEMT services; ○ NEMT & NMT providers arriving within 15 minutes of scheduled appointment time; & ○ No show rates for NEMT & NMT providers. • IEHP PCS Form "NEMT PCS Form" was amended to include the "transportation start date" & "transportation end date" & includes that all fields must be completed as part of IEHP's requirements. **The Corrective Action Plan for Finding 3.8.1 is accepted.**
3.8.2 Enrollment of Subcontracted Transportation Forms The Plan did not have a process in place to ensure its subcontracted transportation providers were enrolled in the Medi-Cal program.	1. **Medi-Cal Enrollment Verification –** The Plan will verify the Medi-Cal enrollment of subcontracted providers on a monthly basis. Findings from this process will be shared with the Transportation vendor on at least a monthly basis and discussed at the quarterly Joint Operations Meetings. 2. **Retrospective Claims Review** – The Plan will retrospectively review transportation claims on a monthly basis to determine	The Plan will provide the following documentation: • JOM Meeting Minutes • Process Documentation – Retrospective Claims Review • Training & communication materials	**Short-Term**: • N/A **Long-Term:** • **06/01/22 –** On or before this date, inform Transportation vendors of Medi-Cal enrollment requirement and oversight plan. • **07/01/22 –** On or before this	The following documentation supports the MCP's efforts to correct this finding: **Policies & Procedures** The Plan updated P&Ps to address the gap that contributed to the deficiency: • P&P "MC_09C NEMT & NMT Services" demonstrates the Plan will be tracking that the transportation broker & providers are complying with all requirements set forth in APL 22-008, ensuring monitoring activities are performed no less than quarterly, including but not limited to Enrollment Status. The P&P also demonstrates the Plan has a corrective action process in place & will impose on its transportation brokers & providers should non-compliance be

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	whether Transportation vendors utilized subcontracted providers who are not enrolled in the Medi-Cal program. Persistent non-compliance will result in corrective action, which may lead to further disciplinary action including but not limited to freezing from referrals. 3. **Training & Communication** • Transportation vendors will be reminded at JOMs of Medi-Cal enrollment requirements, and how their compliance will be monitored going forward. • The appropriate Team Members will be trained on the retrospective claims review process		date, implement retrospective claims review process	identified through monitoring activities. [9. Access Standards, B., page 9] **Implementation/Oversight & Monitoring** The Plan identified, developed and deployed an internal auditing process to continuously self-monitor to detect and prevent future non-compliance: • IEHP Workflow "Transportation Retrospective Review Workflow – IEHP Direct" demonstrates the following: o The Plan monitors & oversees transportation providers through verification of broker/provider roster on a monthly basis, validating Medi-Cal Enrollment data comparison through CHHS ODP, & utilizing the transportation roster. The workflow demonstrates the Plan is ensuring providers are within 120-day requirement, requiring after 90 days in "pending" status, to start preparing Provider termination. o The Plan is currently working with 5 providers to bring into compliance & has submitted a Plan of Action on 11/18/2022 for continuity of services. • Provider Rosters "IEHP Direct Transportation Contracted List & AL-Subcontracted List" demonstrate the following: o The Plan utilizes both direct transportation providers & a transportation broker for NEMT services. o The Plan is currently working with 5 providers to bring into compliance & has submitted a Plan of Action on 11/18/2022 for continuity of services.

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				○ The Plan is monitoring provider enrollment monthly, checking status of each provider to ensure Medi-Cal enrollment requirement is being met. [Column "Enrollment Status DATE"] • P&P "MC_09C NEMT & NMT Services" demonstrates the Plan has a process in place for monitoring activities, occurring no less than quarterly, including but not limited to Enrollment Status. If non-compliance is identified through monitoring activities, this will result in intervention including but not limited to Broker/Provider education, issuance of corrective action, freezing to new authorizations, and leading up to termination of contract. [9. Access Standards, B., page 9] **The Corrective Action Plan for Finding 3.8.2 is accepted.**
4. Member Rights				
4.1.1 Grievance Resolution The Plan did not ensure member grievances were completely resolved due to a lack of response from its network providers.	1. **Obtaining Provider Response** – The Plan will perform additional outreach to Providers that do not meet their response due date. Outreach will be performed telephonically and in writing through Day 25, to obtain the Provider's response prior to case resolution. The Plan will continue to accept and consider Provider	The Plan will provide the following: • Revised Policies and Procedures • Process Documentation – Grievance Resolution • Communication materials	**Short-Term:** N/A **Long-Term:** • **05/23/22** – On or before this date, train G&A Team Members on the outreach process • **06/01/22** – On or before this date, implement	The following documentation supports the MCP's efforts to correct this finding: **Policies & Procedures** - Updated P&P (Provider Policy), "MED_GRV 2: Member Grievance Resolution System – Medi-Cal" (06/01/22) has been updated to include the policy of retrieving the Grievance Summary Form (GSF) from network providers. - Updated P&P (Internal Policy), "MC_16A: Member Grievance Resolution Process" (01/01/22) has been updated to include to include

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	responses in resolving grievance cases through Day 30. Quality of Care (QOC) cases that lack Provider's response and require further documentation to completely resolve the Member's complaint by Day 30 will be escalated to the Medical Director to review for potential quality of care issue and if necessary, the Quality department for additional review. 2. **Training & Communication** – The Plan's G&A Team will be trained on how to perform and document their outreach efforts to obtain the Provider's response. 3. **Oversight** – The Plan will continue its daily review of Level 1 cases and include the QA of outreach efforts.		the outreach process and incorporate in daily QA review.	the policy of retrieving the Grievance Summary Form (GSF) from network providers. **Monitoring** - Internal Monitoring, "Weekly Non-Response Rate" (02/22 – 05/22) The MCP submits its weekly non-responsive rate monitoring report. Which reflects when the MCP started to mediate the audit finding through the Grievance Summary Form (GSF). – Audit Results, "Audit Sample Daily Quality Assurance Report", (04/22) which captures level one cases resolved for the day. Level one is categorized as those providers who did not respond to GSF. In addition, this demonstrates the decrease in non-compliant cases. In the monitoring example submitted by the plan, the rate of provider non-responsiveness decreased from a high of 27% down to a rate of 9% after the plan implemented remediation action. - Instances of Non-Compliance as stated in P&P (Provider Policy), "MED_GRV 2: Member Grievance Resolution System" and P&P (Internal Policy), "MC_16A: Member Grievance Resolution Process", "Continued failure to respond timely to grievance request may result in a corrective action plan, freezing new member assignments, or further disciplinary action up to & including terminated contract." **Training** - PowerPoint Training, GSF Outreach, (03/23/22) and Attendance Log, as evidence that the MCP has provided training in regard to the process of attempts to receive GSF from network providers.

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				Implementation - Notification to Network Providers and IPA's," Response to GSF" (04/27/22) as evidence that the MCP has reached out to its network providers to communicate the importance of responding timely in order to resolve the grievance within 30 days. - Job Aid, "Grievance Summary Form Provider Response Follow Up" (04/21/22) which demonstrates the MCP has a process to receive responses from its network providers in regard to grievances being resolved. **The Corrective Action Plan for Finding 4.1.1 is accepted.**
4.1.2 Escalation of CAP Process The Plan did not ensure corrective actions were enacted when addressing needed improvements to the quality of care delivered by its providers.	1. **Provider CAP Escalation Process** – The Plan will implement a CAP escalation process in Provider Relations that identifies trends in non-response to the Grievance Summary Form (GSF). Persistent non-compliance could result in the Provider being frozen to new Member assignment until the deficiency is fully remediated. This process will include but not be	The Plan will provide the following: • Revised policies and procedures • Process Documentation – Provider CAP Escalation Process • Communication materials	**Short Term:** N/A **Long Term:** • **05/31/22** – On or before this date, Provider Services Representatives will be trained on the Provider CAP escalation process.	The following documentation supports the MCP's efforts to correct this finding: **Policies & Procedure** - Updated P&P, "MED_GRV 2: Member Grievance Resolution System – Medi-Cal" (06/01/22) which states that, Respondents who meet established thresholds for non-response to grievances are referred to the Provider Relations Department for follow-up and potential escalation, including issuance of Corrective Action Plan (CAP), freezing new Member assignments, or further disciplinary action up to and including termination of contract. Respondents that are issued a CAP must submit by the specified due date a completed CAP. IEHP will review the CAP to ensure that all

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	limited to: identification of trends, issuance and approval of CAP responses, escalation of CAPs, and review for further corrective/ disciplinary action. 2. **Delegate CAP Escalation Process** – The Plan will ensure adherence to its current CAP escalation process for Delegates. 3. **Training & Communication** – • Providers will be informed of the CAP escalation process by way of Provider policies and blastfax. • Provider Services Representatives will be trained on the Provider CAP escalation process.		• **06/30/22** – On or before this date, Providers will be informed of CAP escalation process. • **07/01/22** – On or before this date, implement the Provider CAP Escalation process	findings are addressed, and all pertinent information is included. IEHP will either deny or approve the CAP. Respondents that do not submit a complete CAP by the specified due date are escalated up to the Director of Provider Relations. The Director of Provider Relations will outreach to the Respondent regarding their CAP and determine further disciplinary action, which may include freezing new Member assignments until a complete CAP is submitted. Continued non-response to or failure to submit a complete CAP could result in further disciplinary action up to and including termination of contract (4.1.2 1.a CLEAN_MED_GRV 02 - Mmbr Grvnce Resolution System, Page 17). - Updated P&P, "MC_16A: Member Grievance Resolution Process" (01/01/22) which states that, IEHP makes good faith efforts to obtain input from the Provider, Delegate or entity, against whom the Member has filed a grievance, when this is necessary to resolve the Member's complaint, IEHP faxes or emails a Grievance Summary Form (GSF) to a party involved in the grievance, which includes but is not limited to Providers, Delegates, and Hospitals; hereinafter referred to as "Respondent." The GSF contains the substance of the grievance, identified issues to be addressed by the Respondent, and a request for pertinent documents (i.e., medical records, call notes, policies) that may aid in the investigation. Responses are due to IEHP by the due date specified on the GSF. For expedited grievances, the due date may be in less than 24 hours from the time the GSF is sent to the Respondent. When necessary, medical records are requested from the Respondent as part of the grievance investigation process. Respondents must procure and assemble all requested information upon receipt of the GSF. Once a response is received, IEHP reviews the information to ensure all Member issues

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				were addressed. If Member issues are not completely addressed, IEHP notifies the Respondent that additional information is needed. IEHP makes good faith efforts to obtain a complete and timely response to the GSF. If not received by the due date, IEHP will follow-up with the Respondent telephonically and in writing. If IEHP remains unsuccessful in obtaining a response, the grievance is resolved to address the Member's needs based on the available information. Continued failure to respond timely to grievance requests may result in a Corrective Action Plan (CAP), freezing new Member assignments, or further disciplinary action up to and including termination of contract (4.1.2 Item 1.a CLEAN_MC_16A - Member Grievance Resolution Process, Page 11). **Implementation** - Letter Template, "Provider Corrective Action Plan Letter" which requests the provider to submit a CAP within 10 calendar days to address the Root Cause, Resolution/Remediation, Actions to improve patience experience, Expected date of compliance (4.1.2 Item 1.a Provider Corrective Action Plan Letter 2022). - Excel Spreadsheet, "CAP Form" which requests the provider to address the Cause Analysis, Action Plan, and Monitoring Plan (4.1.2 Item 1.b CAP Form). - Letter Template, "Timely Response to the Grievance Summary Form (GSF)" which is sent to providers to stress the requirement of Provider timely response to IEHP's Grievance Summary Form (GSF). To convey the seriousness of non-response, IEHP has included a

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				financial penalty for Provider non-response to the GSF in the 2022 Global Quality (GQ) PCP P4P Program (4.1.2 Item 2.a Provider Communication - GSF Response, Page 2). **Monitoring** - “Provider Grievance CAP Report Dashboard” which is used for monitoring and follow-up of non-compliant Providers on a CAP, as well as identifying Providers that are not compliant with their CAP timelines. The data for this dashboard comes from IEHP’s internal health management system and the dashboard provides a detailed view of Provider CAPs which includes Provider Name, Provider type, CAP status, and date CAP was initiated as well as when it was last updated (Provider Grievance CAP Report). **Procedure** - Desktop Procedure, “Grievance Process for Provider Services – CAP Response Received” as evidence that the MCP has monitoring activities in place after the CAP is issued. The Provider Services Representative (PSR) Validation steps consists of the PSR to visit office to validate changes were completed/implemented. Acceptable validation methods: picture, written verbal, observation by the PSR, phone call to the office, etc. The PSR details in MediTrac the document type validation and whether complete/implemented. The PSR will attach in MediTrac any supporting documents i.e. pictures, letters, etc. (Std Wrk for Grievance_CAP Response Rcvd, Page 4). **The Corrective Action Plan for Finding 4.1.2 is accepted.**

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5. Quality Management				
5.1.1 Quality Improvements The Plan did not maintain adequate oversight of the UM delegates. The Plan did not require delegates to report UM findings quarterly and did not monitor delegate reporting of underutilization.	1. **Reporting Requirements** – Delegates will be required to submit their UM Workplan evaluations quarterly, rather than semi-annually. The UM Workplan will include additional UM measures as approved by the UM Subcommittee. 2. **Delegation Oversight** – The Plan will review UM Workplan evaluations on a quarterly, rather than semi-annual basis. The Plan will provide Delegates with feedback, findings, and areas for improvement. Delegates will be required to engage in proactive interventions through quality improvement activities. 3. **Plan Oversight** – Trends and findings identified from the quarterly review of UM Workplans will be presented to the Plan's UM Subcommittee, which reports to the Quality Management Committee,	The Plan will provide the following: • Revised Policies and Procedures • Communication materials	**Short-Term:** N/A **Long-Term:** • **05/11/22** – On or before, UM Subcommittee will approve of utilization measures • **06/01/22** – On or before this date, Delegates will be informed of changes to the reporting requirements, including utilization measures. • **09/15/22** – ON or before, first quarterly UM Workplan is due to the Plan	The following documentation supports the MCP's efforts to correct this finding: **Policy & Procedures** - Updated P&P, "MC_25E2: Delegation Oversight – Utilization Management – Reporting Requirements" (01/01/21) which states that Delegates will be required to submit their UM Workplan evaluations quarterly, rather than semi-annually (1.c - REDLINED_MC_25E2 - UM Reporting Requirements, Page 2). - Updated P&P, "MED_UM 5.e: Over and Under Utilization Tracking and Reporting" (06/01/22) which states Disease-specific over and under utilization metrics as part of the reporting statistics on a monthly and/or quarterly basis (1.c - REDLINED_MED_UM 05.e - Over&Under Utilization Trckng&Rptg, Page 2). **Implementation** - Communication Letter, "Changes to UM Semi-Annual and Annual Reporting Requirements" (06/01/22) as evidence that the MCP has notified all IPAs that the MCP has increased the reporting frequency of the Health Industry Collaboration Effort (HICE) UM reporting requirements from semi-annually, (February & August) to quarterly, (February, May, August, and November) (2.a - IPA Communication - UM Quarterly HICE Report). - Meeting Minutes, "UM Subcommittee Meeting" (05/11/22) in which the MCP obtained approval of utilization measures to include in the

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	and ultimately to the Plan's Governing Board. 4. **Training & Communication** • Delegates will be informed of change in reporting requirements, benchmarks and oversight process			UM Workplan (1.a - UMSC Meeting Minutes 05.11.22 -Signed, Page 17). **Monitoring** - "UM Delegation Oversight – Quarter 2 2022: UM Health Industry Collaboration Effort (HICE) Work Plan Review" as evidence that the MCP is reviewing over and underutilization metrics submitted by the delegate and providing feedback and requests back to the delegate. The report includes the following categories: Key Findings and Analysis, Interventions/Follow-up Actions, Remeasurement. (1.c - Sample Feedback Summary). - Quarterly 2022 Work Plans, "2022 HICE UM Work Plan" submitted to the MCP from several delegates in which the MCP will review UM Workplan evaluations on a quarterly, rather than semi-annual basis. The MCP will provide delegates with feedback, findings, and areas for improvement. Delegates will be required to engage in proactive interventions through quality improvement activities. The report includes the goals, analysis, interventions, and evaluation in regards to over and underutilization (MCR_Q2_2022_UM WP_IEHP). **The Corrective Action Plan for Finding 5.1.1 is accepted.**

Submitted by: [Plan's signature on file] **Date: 4/8/22**
Title: Erika Oduro, Manager of Regulatory Affairs - Medi-Cal