

DEPARTMENT OF  
**Managed  
Health Care**  
**Help Center**

**DIVISION OF PLAN SURVEYS**

**CAL MEDICCONNECT**

**MEDICAL SURVEY REPORT OF  
INLAND EMPIRE HEALTH PLAN**

**A FULL SERVICE HEALTH PLAN**



**DATE ISSUED TO DHCS: APRIL 4, 2016**

**Cal MediConnect Medical Survey Report  
Inland Empire Health Plan  
A Full Service Health Plan  
April 4, 2016**

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## **EXECUTIVE SUMMARY**

On March 27, 2013, the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) entered into the Coordinated Care Initiative Memorandum of Understanding (MOU). The MOU authorized DHCS to conduct a demonstration project to assess the effectiveness of integrating delivery of health care services covered by Medicare with delivery of long-term care and other services covered by Medicaid (“Medi-Cal” in California) for individuals within California who are eligible for both Medicare and Medicaid benefits. In preparation for the MOU, in January 2012, DHCS had solicited health care service plans; DHCS sought plans that could develop a comprehensive network of health care service and social service providers and thereby deliver and coordinate all Medicare and Medicaid covered benefits for dual eligible individuals under a capitated model of financing (a “Cal MediConnect” plan). Inland Empire Health Plan (IEHP) was one of the health care service plans selected to offer a Cal MediConnect plan for eligible beneficiaries residing in Riverside and San Bernardino counties. A three-way contract between IEHP, DHCS and CMS by which IEHP undertook to offer a Cal MediConnect plan (Cal MediConnect Three-Way Contract) was approved on October 27, 2013.

The Department of Managed Health Care (DMHC) and DHCS entered into an inter-agency agreement<sup>1</sup> (IA Agreement) whereby the DMHC will be responsible for conducting medical survey audits of Cal MediConnect health plans to examine the health plan operations related to the provision of Medicaid-based services. Medical surveys, pursuant to the IA Agreement, are conducted once every three years, as long as the demonstration continues.

On July 16, 2015, the Department notified IEHP that its medical survey had commenced and requested that IEHP provide all necessary pre-onsite data and documentation. The Department’s medical survey team conducted the onsite portion of the medical survey from October 5, 2015 through October 9, 2015.

### **SCOPE OF MEDICAL SURVEY**

As required by the IA Agreement, the DMHC provides this Cal MediConnect Medical Survey Report of IEHP to DHCS. The report identifies potential deficiencies in IEHP operations supporting the provision of Medicaid-based services to the Cal MediConnect population. This medical survey evaluated the following elements specifically related to the IEHP’s delivery of care to the Cal MediConnect population as delineated by the Cal MediConnect Three-Way Contract and the Knox-Keene Health Care Service Plan Act of 1975<sup>2</sup>.

#### **I. Utilization Management**

<sup>1</sup> The IA Agreement (Agreement Number 13-90167) was executed on October 21, 2013, and amended on March 21, 2014.

<sup>2</sup> The Knox-Keene Act is codified at Health and Safety Code section 1340 et seq. All references to “Section” are to the Health and Safety Code unless otherwise indicated. The regulations promulgated from the Knox-Keene Act are codified at Title 28 of the California Code of Regulations section 1000 et seq. All references to “Rule” are to Title 28 of the California Code of Regulations unless otherwise indicated.

The DMHC evaluated IEHP operations related to utilization management as it relates to the provision of Medicaid-based services, including implementation of the Utilization Management Program and policies, processes for effectively handling prior authorization of services, mechanisms for detecting over- and under-utilization of services, and the methods for evaluating utilization management activities of delegated entities.

## **II. Continuity of Care**

The DMHC evaluated IEHP operations to determine whether Medicaid-based services are effectively coordinated both inside and outside the network. The DMHC also verified that IEHP takes steps to facilitate coordination of Medicaid-based services with other services delivered through IEHP'S Cal MediConnect plan, and through the enrollees' primary care physician and/or interdisciplinary care team.

## **III. Availability and Accessibility**

The DMHC evaluated IEHP operations to ensure that its Medicaid-based services are accessible and available to enrollees throughout its service areas within reasonable timeframes, and that IEHP addresses reasonable patient requests for disability accommodations.

## **IV. Member Rights**

The DMHC evaluated IEHP operations to assess compliance with internal and external complaint and grievance system requirements related to the provision of Medicaid-based services. The DMHC also evaluated IEHP's ability to provide interpreter services and communication materials in both threshold languages and alternative formats.

## **V. Quality Management**

The DMHC evaluated IEHP operations to verify that IEHP monitors, evaluates, takes effective action, and maintains a system of accountability to ensure quality of care as it relates to the provision of Medicaid-based services.

The scope of the medical survey incorporated review of health plan documentation and files from the period of October 1, 2014 through September 20, 2015.

**SUMMARY OF FINDINGS**

The DMHC identified **four** potential deficiencies during the current medical survey.

**2015 MEDICAL SURVEY POTENTIAL DEFICIENCIES**

<b>CONTINUITY OF CARE</b>	
<b>#1</b>	<p><b>IEHP’s policy requiring completion of an Individual Care Plan within 90 calendar days of enrollment is inconsistent with the Cal MediConnect Three-Way Contract, which requires completion of the Individual Care Plan within 30 working days of completion of the an Health Risk Assessment, and in practice does not ensure compliance.</b></p> <p>Cal MediConnect Three-way Contract § 2.5.1.6.6.; Cal MediConnect Three-way Contract § 2.5.1.8.2.1; Cal MediConnect Three-way Contract § 2.5.1.10.2.3.; Cal MediConnect Three-way Contract § 2.8.2; Cal MediConnect Three-way Contract § 2.8.3.1.; DHCS Dual Plan Letter 15-001.</p>
<b>#2</b>	<p><b>IEHP’s Internet Web site home page does not provide a hyperlink clearly identified as “GRIEVANCE FORM”, neither does IEHP’s Internet Web site member services portal provide a Hyperlink clearly identified as “GRIEVANCE FORM”.</b></p> <p>Cal MediConnect Three-Way Contract § 2.14.2.1.1 (As amended); Cal MediConnect Three-Way Contract § 2.15.3.3.3.3 (As amended); Section 1368.015, subdivisions (a), (b) and (e).</p>
<b>#3</b>	<p><b>The evidence of coverage distributed to enrollees of IEHP’s Cal MediConnect plan does not display the DMHC’s toll-free telephone number, TDD line for the hearing and speech impaired, and Internet Web site address, nor IEHP’s telephone number, in <u>boldface</u> type.</b></p> <p>Cal MediConnect Three-way Contract § 2.14.2.1.1; Cal MediConnect Three-way Contract § 2.15.3.3.3; Section 1368.02, subdivision (b).</p>
<b>#4</b>	<p><b>The Plan’s policies do not require that IEHP reimburse the provider or enrollee within five working days for disputed services that have already been rendered and have been found to be medically necessary by an independent medical review decision adopted by the DMHC Director.</b></p> <p>Cal MediConnect Three-way Contract § 2.15.3.7; Section 1374.34, subdivision (a).</p>

**OVERVIEW OF THE PLAN’S EFFORTS TO SUPPORT CAL MEDICONNECT ENROLLEES**

**Cal MediConnect:**

- IEHP was founded in 1996 and organized as a Joint Powers Agency providing services to over one million Medi-Cal beneficiaries in Riverside and San Bernardino counties. The service area covers over 55,000 square miles.
- IEHP monitors, evaluates and takes effective action to maintain quality of care and addresses needed improvements in quality. Further, the Plan maintains a system of accountability for quality within the organization including its delegated entities.
- Methodologies and processes were evaluated to assure Medicaid-based services were provided through the provider network and other available providers delivering those services outside its network consistent with the Plan's obligations.
- Compliance with delegation and oversight P&Ps for continuity of care were also evaluated.
- The coordinated care initiative whereby the Plan enrolled approximately 350,000 members in one year, 22,323 of those members were Cal MediConnect members.
- Coordination of planning through a CCI stakeholder advisory committee consisting of county IHSS, county mental health agencies, CBAS providers, healthcare providers and Molina healthcare.
- Integration of care initiative to assure access to care at the point of service for CMC members at FQHCs, assisted living facilities, SNFs, substance abuse, county mental health, CBAS centers and primary care offices.
- Integration of IHSS providers, LTC, CBAS and BH providers into the quality oversight process.
- Upgrade of medical management system to the MEDHOC program on 3/27/14 to capture data from these community based service providers to assure better coordination of care.
- Provider education efforts regarding additional services available to this population to increase awareness.
- The Plan's CMO reported during our interview that the Plan endeavors to establish a medical home for these members where their physical, psychological, and social needs can be addressed including home health for the sickest members (approximately 3000 members identified with 5+ comorbidities).

## DISCUSSION OF POTENTIAL DEFICIENCIES

### CONTINUITY OF CARE

**Deficiency Statement #1:** IEHP's policy requiring completion of an Individual Care Plan within 90 calendar days of enrollment is inconsistent with the Cal MediConnect Three-Way Contract, which requires completion of the Individual Care Plan within 30 working days of completion of the an Health Risk Assessment, and in practice does not ensure compliance.

**Relevant Contract/Section/Rule:** Cal MediConnect Three-way Contract § 2.5.1.6.6.; Cal MediConnect Three-way Contract § 2.5.1.8.2.1; Cal MediConnect Three-way Contract § 2.5.1.10.2.3.; Cal MediConnect Three-way Contract § 2.8.2; Cal MediConnect Three-way Contract § 2.8.3.1.; DHCS Dual Plan Letter 15-001.

#### Cal MediConnect Three-way Contract § 2.5.1.6.6

2.5.1. Care Coordination. The Contractor shall offer care coordination and case management services to all Enrollees, as described in WIC Sections 14182.17(d)(4) and 14186(b). [¶] . . . [¶]

2.5.1.6 Contractor will ensure that care coordination services: [¶] . . . [¶]

2.5.1.6.6. Include development of Individual Care Plans (ICP) with Enrollees, as described in Section 2.8.3; . . .

#### Cal MediConnect Three-way Contract § 2.5.1.8.2.1

2.5.1.8. Interdisciplinary Care Team (ICT). The Contractor shall offer an ICT for each Enrollee, as necessary, which will be developed around the Enrollee and ensure the integration of the Enrollee's medical and LTSS and the coordination of Behavioral Health Services delivered by a county Behavioral Health agency, when applicable.

2.5.1.8.1. Every Enrollee will have access to an ICT if requested.

2.5.1.8.2. ICT Functions. ICT will facilitate care management, including assessment, care planning, and authorization of services, transitional care issues and work closely with providers listed in Section 2.5.1.8.3.2 to stabilize medical conditions, increase compliance with care plans, maintain functional status, and meet individual Enrollees care plan goals. ICT functions will include, at a minimum:

2.5.1.8.2.1. Develop and implement an ICP with Enrollee and/or caregiver participation as further described in Sections 2.5.1.9 and 2.8.3; . . .

#### Cal MediConnect Three-way Contract § 2.5.1.10.2.3

2.5.1.10. Basic Case Management. The PCP and/or Care Coordinator, in collaboration with the Contractor, will provide basic case management services. [¶] . . . [¶]

2.5.1.10.2 Basic case management services include: [¶] . . . [¶]

2.5.1.10.2.3. Creation of the ICP, in collaboration with the ICT (see Section 2.8.3); . . .

#### Cal MediConnect Three-way Contract § 2.8.2

2.8.2. Health Risk Assessment (HRA). In accordance with all applicable federal and state laws WIC Section 14182.17(d)(2), the CMS Model of Care requirements, Dual Plan Letter 13-002, Contractor will complete HRAs for all Enrollees.

Cal MediConnect Three-way Contract § 2.8.3.1

2.8.3 Individualized Care Plan (ICP). An ICP will be developed for each Enrollee that includes Enrollee goals and preferences, measurable objectives and timetables to meet medical needs, Behavioral Health and LTSS needs. It must include timeframes for reassessment. See Section 2.5.1.9.

2.8.3.1. ICPs will be developed within thirty (30) working days of HRA completion.

DHCS Dual Plan Letter 15-001

This letter clarifies requirements for Interdisciplinary Care Teams and Individual Care Plans for plans participating in Cal MediConnect.

**Documents Reviewed:**

- IEHP Medical Services Policy # MED\_CM 7.g; Subject: *Health Risk Assessment – IEHP DualChoice Cal MediConnect Plan (Medicare – Medi-Cal Plan) Members*; Effective Date: July 1, 2014 [hereafter “**HRA Policy**”]
- IEHP Medical Services Policy # MED\_CM 7.i; Subject: *Individual Care Plan – IEHP DualChoice Cal MediConnect Plan (Medicare – Medi-Cal Plan) Members and Members enrolled in Long Term Services and Supports (LTSS)*; Revision Date: July 1, 2015 [hereafter “**ICP Policy**”]

**Assessment/Summary:**

Cal MediConnect plans are required to develop Individual Care Plans (ICP) for those enrollees whose health risk requires greater care coordination and for those enrollees that request an ICP. (See Cal MediConnect Three-way Contract § 2.51.6.6; § 2.5.1.8.2.1; § 2.5.1.10.2.3 and § 2.8.3.) An ICP must be developed by an enrollee’s Interdisciplinary Care Team (ICT) and is the ICT’s plan to ensure that an enrollee’s benefits and services, such as medical, behavioral health and long-term supports, are integrated, and that an enrollee’s care is coordinated. (See Cal MediConnect Three-way Contract § 2.5.1.8.) An ICP must include an enrollee’s goals and preferences, measurable objectives and timetables to meet medical, behavioral health and long-term support needs. (See Cal MediConnect Three-way Contract § 2.8.3.) Cal MediConnect Three-way Contract § 2.8.3.1. specifies that ICPs will be developed within 30 working days of Health Risk Assessment (HRA) completion. (See Cal MediConnect Three-way Contract § 2.8.2.)

IEHP provided its HRA and ICP Policies for the Department’s review. IEHP’s HRA Policy, at page 8, Clause A under **Care Plan Development**, states: “The completed HRA shall be utilized to develop a Care Plan within 90 calendar days of enrollment.” IEHP’s ICP Policy, at page 1, Clause B under **Policy**, likewise states: “The ICP will be developed within ninety (90) calendar days of enrollment for new Members upon completion of the initial risk data stratification and Health Risk Assessment (HRA).”

These policies are inconsistent with the Cal MediConnect Three-way Contract and, in practice, IEHP’s policies do not ensure compliance. The Cal MediConnect Three-way Contract requires that plans measure the time within which the ICP must be completed according to the date the HRA is completed. (See Cal MediConnect Three-way Contract § 2.8.3.1.) While IEHP’s policy requiring completion of the ICP within 90 calendar days of enrollment does not prevent compliance with the Cal MediConnect Three-way Contract. For instance, if an HRA is completed 60 calendar days after enrollment the ICP would necessarily need to be completed within 30 working days to comply with IEHP’s policies. However, during the onsite portion of the survey the DMHC did not find compliance. The DMHC reviewed 66 ICP files. Of those 66 files, 19<sup>3</sup> (29%) were determined to be non-compliant for having been developed more than 30 working days from HRA completion.

During onsite interviews with IEHP’s Director of Compliance, the Department asked about the delay in completion of ICPs. The Director of Compliance indicated that IEHP had experienced a 30% error rate in DHCS’s demographic information making it difficult to contact new enrollees. Further, not all members were willing to participate with the HRA or ICP process when contacted. Additionally, during the survey period IEHP underwent a system conversion to the MEDHOC system, this conversion also delayed completion of some of the evaluations.

The Department finds IEHP out of compliance with Cal MediConnect Prime Contract Section 2.5.1.6.6.; Cal MediConnect Prime Contract Section 2.5.1.10.2.3.; Cal MediConnect Prime Contract Section 2.8.3.1.; and the All Plan Letter 15-001 for not developing ICPs within 30 working days of HRA completion.

**TABLE A**

<b>FILE TYPE</b>	<b>NUMBER</b>	<b>ELEMENT</b>	<b>COMPLIANT</b>	<b>DEFICIENT</b>
Individual Care Plans (ICP)	66	Did the Plan complete the ICP within 30 working days of completion of the HRA	47 (71%)	19 (29%)

<sup>3</sup> 201204000684, 201302000815, 201501000928, 200812004851, 201308012120, 201303001304, 201302000049, 201209007578, 200612000628, 199702000999, 201302003547, 201110007623, 201501002374, 200601002343, 201005001240, 201501003361, 201002008575, 201004006235, 201303004340

## MEMBER RIGHTS

**Deficiency Statement #2:** IEHP's Internet Web site home page does not provide a hyperlink clearly identified as "GRIEVANCE FORM", neither does IEHP's Internet Web site member services portal provide a Hyperlink clearly identified as "GRIEVANCE FORM".

**Relevant Contract/Section/Rule:** Cal MediConnect Three-Way Contract § 2.14.2.1.1 (As amended); Cal MediConnect Three-Way Contract § 2.15.3.3.3.3 (As amended); Section 1368.015, subdivisions (a), (b) and (e).

Cal MediConnect Three-Way Contract § 2.14.2.1.1 (As amended)

2.14.2.1.1 Internal Grievance: Contractor shall establish and maintain a grievance process under which Enrollees may submit their grievance regarding all covered services and benefits to the Contractor. Contractor shall establish and maintain a grievance process approved by DHCS under which enrollees may submit their grievances regarding all benefits and services, pursuant to the Knox-Keene Health Care Services Plan Act of 1975, and the regulations promulgated thereunder, WIC Section 14450 and CCR, Title 22, Section 53260.

Cal MediConnect Three-Way Contract § 2.15.3.3.3 (As amended)

2.15.3.3 Contractor shall implement and maintain an Enrollee internal Appeals system, which includes oversight of any First Tier, Downstream or Related Entity, in accordance with all applicable federal and state laws and regulations, including but not limited to the following: [¶] . . . [¶]

2.15.3.3.3 Internal Contractor Appeal processes, in accordance with the Knox-Keene Act and the regulations promulgated thereunder, as applicable, and external Appeal processes in accordance with the DMHC's Independent Medical Review System set forth in Article 5.55 of the Knox-Keene Act (commencing with Health & Safety Code section 1374.30) and the regulations promulgated thereunder, and the fair hearing standards for Medi-Cal managed care, Title 22, CCR, sections 51014.1, 51014.2, 53894 and 53858.

Section 1368.015, subdivisions (a), (b) and (e)

(a) Effective July 1, 2003, every plan with an Internet Web site shall provide an online form through its Internet Web site that subscribers or enrollees can use to file with the plan a grievance, as described in Section 1368, online.

(b) The Internet Web site shall have an easily accessible online grievance submission procedure that shall be accessible through a hyperlink on the Internet Web site's home page or member services portal clearly identified as "GRIEVANCE FORM." All information submitted through this process shall be processed through a secure server.

(e) For purposes of this section, the following terms shall have the following meanings:

(1) "Homepage" means the first page or welcome page of an Internet Web site that serves as a starting point for navigation of the Internet Web site.

(2) “HTML” means Hypertext Markup Language, the authoring language used to create documents on the World Wide Web, which defines the structure and layout of a Web document.

(3) “Hyperlink” means a special HTML code that allows text or graphics to serve as a link that, when clicked on, takes a user to another place in the same document, to another document, or to another Internet Web site or Web page.

(4) “Member services portal” means the first page or welcome page of an Internet Web site that can be reached directly by the Internet Web site's homepage and that serves as a starting point for a navigation of member services available on the Internet Web site.

(5) “Secure server” means an Internet connection to an Internet Web site that encrypts and decrypts transmissions, protecting them against third-party tampering and allowing for the secure transfer of data.

(6) “URL” or “Uniform Resource Locator” means the address of an Internet Web site or the location of a resource on the World Wide Web that allows a browser to locate and retrieve the Internet Web site or the resource.

(7) “Internet Web site” means a site or location on the World Wide Web.

#### **Documents Reviewed:**

- <https://ww3.iehp.org/> (March 8, 2016)
- <https://ww3.iehp.org/en/members/> (March 8, 2016)

#### **Assessment:**

During the onsite survey, IEHP provided an online walkthrough of its member website. Based on the walkthrough provided by IEHP, it was determined that there is no hyperlink on IEHP’s Internet Web site home page, nor member services portal, clearly identified as “GRIEVANCE FORM” pursuant to Section 1368.015, subdivision (b). In order for a member to reach an online grievance form, the member must click on “Report an Issue” on the “Member” page, and select “Report a problem with your care.” This would then allow a member to select the “Online grievance form” which links to the “Member Complaint Form.”

Since neither the home page, nor the member services portal, at IEHP’s Internet Web site include an easily accessible hyperlink labeled as “GRIEVANCE FORM”, the DMHC finds IEHP out of compliance with Cal MediConnect Prime Contract §§ 2.14.2.1.1 and 2.15.3.3.3.

**Deficiency Statement #3:** The evidence of coverage distributed to enrollees of IEHP’s Cal MediConnect plan does not display the DMHC’s toll-free telephone number, TDD line for the hearing and speech impaired, and Internet Web site address, nor IEHP’s telephone number, in boldface type.

**Relevant Contract/Section/Rule:** Cal MediConnect Three-way Contract § 2.14.2.1.1; Cal MediConnect Three-way Contract § 2.15.3.3.3; Section 1368.02, subdivision (b).

#### Cal MediConnect Three-way Contract § 2.14.2.1.1 (As amended)

2.14.2.1.1 Internal Grievance: Contractor shall establish and maintain a grievance process under which Enrollees may submit their grievance regarding all covered services

and benefits to the Contractor. Contractor shall establish and maintain a grievance process approved by DHCS under which enrollees may submit their grievances regarding all benefits and services, pursuant to the Knox-Keene Health Care Services Plan Act of 1975, and the regulations promulgated thereunder, WIC Section 14450 and CCR, Title 22, Section 53260.

Cal MediConnect Three-way Contract § 2.15.3.3.3 (As amended)

2.15.3.3 Contractor shall implement and maintain an Enrollee internal Appeals system, which includes oversight of any First Tier, Downstream or Related Entity, in accordance with all applicable federal and state laws and regulations, including but not limited to the following: [¶] . . . [¶]

2.15.3.3.3 Internal Contractor Appeal processes, in accordance with the Knox-Keene Act and the regulations promulgated thereunder, as applicable, and external Appeal processes in accordance with the DMHC's Independent Medical Review System set forth in Article 5.55 of the Knox-Keene Act (commenign cwith Health & Safety Code section 1374.30) and the regulations promulgated thereunder, and the fair hearing standards for Medi-Cal managed care, Title 22, CCR, sections 51014.1, 51014.2, 53894 and 53858.

Section 1368.02, subdivision (b)

(b) Every health care service plan shall publish the department's toll-free telephone number, the department's TDD line for the hearing and speech impaired, the plan's telephone number, and the department's Internet Web site address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The department's telephone number, the department's TDD line, the plan's telephone number, and the department's Internet Web site address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (**insert health plan's telephone number**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD

line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online."

**Documents Reviewed:**

- *Member Handbook IEHP DualChoice Cal MediConnect Plan (2014)*
- *Member Handbook IEHP DualChoice Cal MediConnect Plan (2015)*

**Assessment:**

Cal MediConnect plans are required to establish and maintain grievance and appeals processes, through which enrollees may submit grievances and appeals concerning Medi-Cal covered services, compliant with the Knox-Keene Act. In order to have Knox-Keene Act compliant grievances and appeals processes, every plan must publish the DMHC's toll-free telephone number, TDD line for the hearing and speech impaired, and Internet address, as well as the plan's telephone number, on every evidence of coverage, pursuant to Section 1368.02, subdivision (b). Each of those items must also be displayed in the evidence of coverage in 12-point boldface type.

IEHP submitted for the DMHC's review evidences of coverage for plan years 2014 and 2015, each titled *Member Handbook IEHP DualChoice Cal MediConnect Plan*. Each *Member Handbook* does include the DMHC's toll-free telephone number, TDD line for the hearing and speech impaired, and Internet address, as well as the plan's telephone number, but those items are not displayed in 12-point boldface type pursuant to Section 1368.02, subdivision (b). As such, the DMHC finds IEHP out of compliance with Cal MediConnect Three-way Contract §§ 2.14.2.1.1 and 2.15.3.3.3 and Section 1368.02(b).

**Deficiency Statement #4:** The Plan's policies do not require that IEHP reimburse the provider or enrollee within five working days for disputed services that have already been rendered and have been found to be medically necessary by an independent medical review decision adopted by the DMHC Director.

**Relevant Contract/Section/Rule:** Cal MediConnect Three-way Contract § 2.15.3.7; Section 1374.34, subdivision (a).

Cal MediConnect Three-way Contract § 2.15.3.7 (As Amended)

2.15.3.7 Responsibilities in Independent Medical Reviews (IMR) Related to Medi-Cal Benefits and Services. Contractor shall comply with all statutes, regulations and procedures regarding the DMHC's Independent Medical Review System, as set forth in the Knox-Keene Act and the regulations promulgated thereunder, . . . .

Section 1374.34, subdivision (a)

(a) Upon receiving the decision adopted by the director pursuant to Section 1374.33 that a disputed health care service is medically necessary, the plan shall promptly implement the decision. In the case of reimbursement for services already rendered, the plan shall reimburse the provider or enrollee, whichever applies, within five working days. In the case of services not yet rendered, the plan shall authorize the services within five working days of receipt of the

written decision from the director, or sooner if appropriate for the nature of the enrollee's medical condition, and shall inform the enrollee and provider of the authorization in accordance with the requirements of paragraph (3) of subdivision (h) of Section 1367.01.

**Documents Reviewed:**

- IEHP Medical Services Policy # MED\_GRV4; Subject: *IEHP Member Appeal Resolution System*; Revised Date: March 3, 2015 [**hereafter “Appeal Resolution Policy”**]
- IEHP Operations - Claims Policy #OPS/CLM P-16; Subject: *Member Bill Reimbursement Requests*; Revised Date: 01/01/2015 [**hereafter ‘Reimbursement Policy’**]

**Assessment:**

IEHP submitted its Appeal Resolution Policy for the DMHC’s review before the onsite survey. The Appeal Resolution Policy states, on page 11 at subsection L.2:

2. In any case where a Member received urgent care or emergency services by a non-contracted provider and the services are later found by the IMR organization to have been medically necessary, the Member is promptly reimbursed for any reasonable costs associated with those services.

During onsite interviews with IEHP staff, the Department asked IEHP to clarify “promptly reimbursed.” In response, IEHP staff provided its Reimbursement Policy which states, on page 1 in the last paragraph under “*POLICY*”:

Members have up to one year (365 days) from the date of service to file a claim for reimbursement with IEHP. IEHP will reimburse claims for covered services within 30-days of receipt.

The Department finds the Plan out of compliance with Cal MediConnect Three-way Contract § 2.15.3.7 and Section 1374.34, subdivision (a), for having a policy that is inconsistent with the requirements of the Contract and Knox-Keene Act. IEHP’s policies do not require that IEHP reimburse enrollees and providers for disputed services already rendered within five working days of the date the DMHC’s Director has adopted an independent medical review decision holding that the disputed services were medically necessary.

<b>APPENDIX A. MEDICAL SURVEY TEAM MEMBERS</b>
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<b>DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS</b>	
Porscha Brink	Medical Survey Team Lead
Cindy Liu	Attorney
<b>Consulting group of WeiserMazars TEAM MEMBERS</b>	
Sheila Muller	Utilization Management Surveyor
Dr. James Hendrickson	Quality Management Surveyor/Continuity of Care Surveyor
Gerry Long	Availability & Accessibility Surveyor
Tony Browne	Member Rights Surveyor

**APPENDIX B. PLAN STAFF INTERVIEWED**

<b>PLAN STAFF INTERVIEWED</b>	
Brad Gilbert, MD	Chief Executive Officer
William Henning, DO	Chief Medical Officer
Rohit Gupta	Compliance Officer
Steve Sohn	General Counsel
Ernesto Campos, DO	Physician Responsible for Quality Management (QM)
Valerie Graham-Martinez	Person responsible for managing QM Program
Glen Thomazin, DO	Person responsible for clinical practice guidelines
Susie White Kurt Hubler	Person responsible for oversight of delegation arrangements
Susie White Glen Thomazin, DO	Person responsible for Peer Review and 805 Reporting
Glen Thomazin, DO	Physician responsible for Utilization Management (UM)
Johnis Saczynski Kathryn Gray	Person responsible for managing UM Program
Jeanna Kendrick	Person responsible for disease management
Dr. Chris Chan	Pharmacy Director
Susie White	Person responsible for availability of primary care physicians (PCPs) & specialty care providers (SCPs)
Susie White Valerie Graham-Martinez	Person responsible for availability of appointments, access & availability of services
Susie White	Person responsible for credentialing and recredentialing
Valerie Graham-Martinez	Person responsible for physicians' site visits
Valerie Graham-Martinez	Person responsible for medical records review
Valerie Graham-Martinez	Person responsible for the grievance system
Valerie Graham-Martinez	Person responsible for the day-to-day management of grievance and appeals staff
Valerie Graham-Martinez	Person(s) responsible for the daily processing and review of enrollee grievances and appeals
Valerie Graham-Martinez	Person(s) responsible for the enrollee grievance and appeal intake process
Renee Mercer	Person responsible for member services
Sue Gengler, Dr.PH, MCHES	Person responsible for Language Assistance Program

**APPENDIX C. LIST OF FILES REVIEWED**

*Note: The statistical methodology utilized by the Department is based on an 80% confidence level with a 7% margin of error. Each file review criterion is assessed at a 90% compliance rate.*

Type of Case Files Reviewed	Sample Size (Number of Files Reviewed)	Explanation
<b>Standard Grievance and Appeals</b>	5	The Plan identified a universe of 5 files during the review period. The Department reviewed all 5 files.
<b>Potential Quality Issues</b>	3	The Plan identified a universe of 3 files during the review period. The Department reviewed all 3 files.
<b>Individual Care Plans</b>	66	The Plan identified a universe of 985 files during the review period. A random sample of 66 files was reviewed.