DEPARTMENT OF
Managed
Health Care
Help Center

DIVISION OF PLAN SURVEYS

1115 WAIVER SENIORS AND PERSONS WITH DISABILITIES

MEDICAL SURVEY REPORT OF

INLAND EMPIRE HEALTH PLAN

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO DHCS: APRIL 4, 2016

1115 Waiver SPD Medical Survey Report
Inland Empire Health Plan
A Full Service Health Plan
April 4, 2016

TABLE OF CONTENTS

EXECUTIVE SUMMARY 1

DISCUSSION OF POTENTIAL DEFICIENCIES 5

UTILIZATION MANAGEMENT 5

QUALITY MANAGEMENT 7

APPENDIX A. MEDICAL SURVEY TEAM MEMBERS 10

APPENDIX B. PLAN STAFF INTERVIEWED 11

APPENDIX C. LIST OF FILES REVIEWED 12

EXECUTIVE SUMMARY

The California Department of Health Care Services ("DHCS") received authorization ("1115 Waiver") from the federal government to conduct mandatory enrollment of seniors and persons with disabilities ("SPD") into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes. The DHCS then entered into an Inter-Agency Agreement[1] with the Department of Managed Health Care (the "Department") to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California's strong patient-rights laws. Mandatory enrollment of SPDs into managed care began in June 2011.

On July 15, 2015 the California Department of Managed Health Care (the "Department") notified Inland Empire Health Plan (the "Plan" or "IEHP") that its Routine Survey had commenced, and requested the Plan to submit information regarding its health care delivery system. The survey team conducted the onsite portion of the survey from October 5, 2015 through October 9, 2015.

SCOPE OF MEDICAL SURVEY

As required by the Inter-Agency Agreements, the Department provides the 1115 Waiver SPD Medical Survey Report to the DHCS. The report identifies potential deficiencies in Plan operations supporting the SPD populations. This medical survey evaluated the following elements specifically related to the Plan's delivery of care to the SPD populations as delineated by the DHCS-IEHP Contract, the Knox-Keene Act, and Title 28 of the California Code of Regulations:[2]

I. Utilization Management
The Department evaluated Plan operations related to utilization management, including implementation of the Utilization Management Program and policies, processes for effectively handling prior authorization of services, mechanisms for detecting under- and over-utilization of services, and the methods for evaluating utilization management activities of delegated entities.

II. Continuity of Care
The Department evaluated Plan operations to determine whether medically necessary services are effectively coordinated both inside and outside the network, to ensure the coordination of special arrangement services, and to verify that the Plan provides for completion of covered services by a non-participating provider when required.

[1] The Inter-Agency Agreement (Agreement Number 10-87255) was approved on September 20, 2011.
[2] All references to "Contract" are to the County Organized Health System, Geographic Managed Care, and Two-Plan contracts issued by the DHCS. All references to "Section" are to the Knox-Keene Act of the Health and Safety Code. All references to "Rule" are to Title 28 of the California Code of Regulations.

III. Availability and Accessibility

The Department evaluated Plan operations to ensure that its services are accessible and available to enrollees throughout its service areas within reasonable timeframes, and are addressing reasonable patient requests for disability accommodations.

IV. Member Rights

The Department evaluated Plan operations to assess compliance with complaint and grievance system requirements, to ensure processes are in place for Primary Care Physician (PCP) selection and assignment, and to evaluate the Plan's ability to provide interpreter services and communication materials in both threshold languages and alternative formats.

V. Quality Management

The Department evaluated Plan operations to verify that the Plan monitors, evaluates, takes effective action, and maintains a system of accountability to ensure quality of care.

The scope of the medical survey incorporated review of health plan documentation and files from the period of October 1, 2014 through August 17, 2015.

SUMMARY OF FINDINGS

The Department identified **two** potential deficiencies during the current medical survey.

2015 MEDICAL SURVEY POTENTIAL DEFICIENCIES

UTILIZATION MANAGEMENT	
#1	**The Plan's policies and procedures do not specify that the Plan shall approve or disapprove post-stabilization care within one half hour of the request. The policies do not specify that if the Plan fails to approve or disapprove the request within 30 minutes, the care shall be deemed authorized.** DHCS-IEHP Contract, Exhibit A, Attachment 8 – Provider Compensation Arrangements, Provision 13 – Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization; Rule 1300.71.4(b)(2)
#2	**The Plan does not consistently report serious quality deficiencies that result in the termination of a practitioner to the appropriate authorities.** DHCS-IEHP Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement and Provision 12 – Credentialing and Recredentialing; Rule 1300.70(b)(2)(C); California Business and Professions Code Sections 805 and 805.01

OVERVIEW OF THE PLAN'S EFFORTS TO SUPPORT SPD

- 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 (SB) counties. The service area covers over 55,000 square miles.
- The Plan has undertaken activities that address not only the specific needs of its SPD population, but benefit its entire membership. Noteworthy are the following:
    - Visionary leadership: The Plan's CEO successfully led the organization through a change management process to organize and improve the delivery of quality, accessible, and wellness based healthcare during a time of rapid growth of membership including over 75,000 SPD members.
    - Culture of caring: Evident throughout the interview process was a passion and commitment to care for this vulnerable population.
    - Support of an active, ongoing, and comprehensive quality management program with the primary goal of continually monitoring and improving the quality of care, patient safety, and services delivered to members. The quality management (QM) program provides a formal process to systematically monitor and objectively evaluate, track, and trend quality, efficiency, and effectiveness. The purpose, goals, and strategy are comprehensive as evidenced by National Committee for Quality Assurance (NCQA) accreditation.
    - Coordination of multi-agency efforts to provide behavioral health services to this population including SB and Riverside county mental health agencies which provide services for the severely challenged members in this population.
    - The integration initiative to deliver primary care at the point of service.
    - Network expansion: Funding approved to attract new physicians, especially PCPs and critical specialists.
    - Implementation of a new care management system to capture findings from the initial health assessments and promptly integrate those findings into individual care plans.
    - Ensuring the coordination of special arrangement services including but not limited to California Children's Services, Child Health and Disability Prevention, Early Start, and Regional Centers in a complex network of public and private entities using a multidisciplinary team approach.

DISCUSSION OF POTENTIAL DEFICIENCIES

UTILIZATION MANAGEMENT

Potential Deficiency Statement #1: The Plan's policies and procedures do not specify that the Plan shall approve or disapprove post-stabilization care within one half-hour of the request. The policies do not specify that if the Plan fails to approve or disapprove the request within 30 minutes, the care shall be deemed authorized.

Contractual/Statutory/Regulatory Reference(s): DHCS-IEHP Contract, Exhibit A, Attachment 8 – Provider Compensation Arrangements, Provision 13 – Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization; Rule 1300.71.4(b)(2)

DHCS-Plan Contract, Exhibit A, Attachment 8 – Provider Compensation Arrangements, Provision 13 – Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization

G. In accordance with California Code of Regulations, Title 28, Section 1300.71.4, Contractor shall approve or disapprove a request for post-stabilization inpatient services made by a non-contracting provider on behalf of a Member within 30 minutes of the request. If Contractor fails to approve or disapprove authorization within the required timeframe, the authorization will be deemed approved. . . .
I. Contractor is also financially responsible for post-stabilization care services obtained within or outside Contractor's network that are not pre-approved by a plan provider or other entity representative, but administered to maintain, improve or resolve the enrollee's stabilized condition if Contractor does not respond to a request for pre-approval within 30 minutes; Contractor cannot be contacted; or Contractor's representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, Contractor must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria of 422.133(c)(3) is met.

Rule 1300.71.4
(b) In the case when an enrollee is stabilized but the health care provider believes that the enrollee requires additional medically necessary health care services and may not be discharged safely, the following applies: . . .
(2) If a health care service plan fails to approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half-hour of the request, the necessary post-stabilization medical care shall be deemed authorized. …

Documents Reviewed:

- Policy MED_UM 4.f - Emergent/Urgent Care Guidelines (July 1, 2015)

Assessment: The Plan submitted its Emergent and Urgent Care Guidelines policy (guidelines) as part of the documents requested by the Department prior to the onsite survey. When an enrollee is stabilized but the provider believes the enrollee requires additional medically necessary health care services and may not be discharged safely, the guidelines do not state that

if the Plan fails to approve or disapprove a request for authorization to provide necessary post-stabilization medical care within one half-hour, the necessary post-stabilization medical care shall be deemed authorized.

During onsite interviews, the Plan agreed and acknowledged that the guidelines failed to specify that the Plan shall approve or disapprove requests for necessary post-stabilization medical care within one half-hour of the request, or the request shall be deemed authorized.

The Department finds the Plan out of compliance with DHCS -IEHP Contract, Exhibit A, Attachment 8 – Provider Compensation Arrangements, Provision 13 – Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization and Rule 1300.71.4(b)(2).

QUALITY MANAGEMENT

Potential Deficiency Statement #2: The Plan does not consistently report serious quality deficiencies that result in the termination of a practitioner to the appropriate authorities.

Contractual/Statutory/Regulatory Reference(s): DHCS-IEHP Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provision 1 – General Requirement and Provision 12 – Credentialing and Recredentialing; Rule 1300.70(b)(2)(C); California Business and Professions Code Sections 805 and 805.01

DHCS-IEHP Contract, Exhibit A, Attachment 4 – Quality and Improvement System

Provision 1 - General Requirement
Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider. …

Provision 12 - Credentialing and Recredentialing
D. Disciplinary Actions
Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating a practitioner's privileges. . . .

Rule 1300.70(b)(2)(C)
… The plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. …

California Business and Professions Code Section 805
(a) As used in this section, the following terms have the following definitions:
(1) (A) "Peer review" means both of the following:
(i) A process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of licentiates to make recommendations for quality improvement and education, if necessary, in order to do either or both of the following:
(I) Determine whether a licentiate may practice or continue to practice in a health care facility, clinic, or other setting providing medical services, and, if so, to determine the parameters of that practice.
(II) Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services.
(ii) Any other activities of a peer review body as specified in subparagraph (B).
(B) “Peer review body” includes:

(i) A medical or professional staff of any health care facility or clinic licensed under Division 2 (commencing with Section 1200) of the Health and Safety Code or of a facility certified to participate in the federal Medicare program as an ambulatory surgical center.
(ii) A health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a disability insurer that contracts with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code.
(iii) Any medical, psychological, marriage and family therapy, social work, professional clinical counselor, dental, or podiatric professional society having as members at least 25 percent of the eligible licentiates in the area in which it functions (which must include at least one county), which is not organized for profit and which has been determined to be exempt from taxes pursuant to Section 23701 of the Revenue and Taxation Code.
(iv) A committee organized by any entity consisting of or employing more than 25 licentiates of the same class that functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity. . . .
(7) "805 report" means the written report required under subdivision (b).
(b) The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file a report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body:
(1) A licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason.
(2) A licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.
(3) Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.

<u>California Business and Professions Code Section 805.01</u>
<u>(a) As used in this section, the following terms have the following definitions: . . .</u>
<u>(2) "Formal investigation" means an investigation performed by a peer review body based on an allegation that any of the acts listed in paragraphs (1) to (4), inclusive, of subdivision (b) occurred. . . .</u>
<u>(4) "Peer review body" has the same meaning as defined in Section 805.</u>
(b) The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file a report with the relevant agency within 15 days after a peer review body makes a final decision or recommendation regarding the disciplinary action, as specified in subdivision (b) of Section 805, resulting in a final proposed action to be taken against a licentiate based on the peer review body's determination, following formal investigation of the licentiate, that any of the acts listed in paragraphs (1) to (4), inclusive, may have occurred, regardless of whether a hearing is held pursuant to Section 809.2. The licentiate shall receive a notice of the proposed action as set forth in Section 809.1, which shall also include a notice advising the licentiate of the right to submit additional explanatory or exculpatory statements electronically or otherwise. . . .(3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances

without a good faith effort prior examination of the patient and medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain, consistent with lawful prescribing, be reported for excessive prescribing and prompt review of the applicability of these provisions shall be made in any complaint that may implicate these provisions. . . .
(e) The report required under this section shall be in addition to any report required under Section 805.
(f) A peer review body shall not be required to make a report pursuant to this section if that body does not make a final decision or recommendation regarding the disciplinary action to be taken against a licentiate based on the body's determination that any of the acts listed in paragraphs (1) to (4), inclusive, of subdivision (b) may have occurred.

Documents Reviewed:

- IEHP Provider Policy and Procedure Manual, Medi-Cal, July 2014
- 805 reports filed by the Plan (6)

Assessment: The Department conducted onsite review of six 805 reports which had been filed by the Plan. Two of the six files involved:

> Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefore.

During an onsite interview with the Plan's Chief Medical Officer, Senior Medical Director, and Credentialing Manager, the Department asked if an 805.01 report had been filed regarding two individual providers. The Plan responded that they had not filed the 805.01 reports, and were unaware of the reporting requirement.

One of the 805 reports filed by the Plan was regarding a physician who was terminated on September 28, 2014 but was allowed to see patients until December 1, 2014. The Department discussed this issue with the Chief Medical Officer, and inquired why the Plan allowed a provider who was terminated to continue seeing members. The Chief Medical Officer responded that this physician was a pain management anesthesiologist practicing in the Hemet area, and had a number of IEHP members in his practice who were in the middle of care. Unfortunately, there were no alternatives for pain management in this rural service area where these members resided and the Plan did not want to disrupt the care of members until a suitable replacement provider could be identified. The process of transferring members individually took until December to complete.

The Department finds the Plan out of compliance with California Business and Professions Code Section 805.01 for not following the appropriate reporting requirements. Therefore, the Department finds the Plan out of compliance with the applicable contractual and regulatory requirements.

APPENDIX A. MEDICAL SURVEY TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS	
Porscha Brink	Medical Survey Team Lead
Cindy Liu	Attorney
Consulting Group of WeiserMazars TEAM MEMBERS	
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

PLAN STAFF INTERVIEWED	
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)	
Standard Grievance and Appeals	74	The Plan identified a universe of 1130 files during the review period. Based on the Department's File Review Methodology, a random sample of 74 files were reviewed.
Expedited Grievance and Appeals	18	The Plan identified a universe of 18 files during the review period. The Department reviewed all 18 files.
Potential Quality Issues	51	The Plan identified a universe of 51 files during the review period. The Department reviewed all 51 files.
UM Medical Necessity Denials	81	The Plan identified a universe of 6860 files during the review period. Based on the Department's File Review Methodology, a random sample of 81 files were reviewed.