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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

July 11, 2019

Rebecca Mayer, MPA State Programs Compliance Manager
Inland Empire Health Plan
10801 6th Street, Suite 120
Rancho Cucamonga, CA 91730

RE: Department of Health Care Services Medical Audit

Dear Ms. Mayer:

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 24, 2018 through October 5, 2018. The survey covered the period of October 1, 2017 through September 30, 2018.

On May 15, 2019, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on January 17, 2019.

All items have been reviewed and DHCS accepts the MCP's submitted CAP. The CAP is hereby closed. Full implementation of the CAP will be monitored on the subsequent audit. The enclosed report will serve as DHCS' final response to the MCP's CAP.

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

If you have any questions, feel free to contact me at (916) 345-7829 or Cristelyn Rebuyon at (916) 345-7832.

Sincerely,

Michael Pank, Chief
Compliance Unit

Enclosures: Attachment A CAP Response Form

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

ATTACHMENT A
Corrective Action Plan Response Form

Plan: Inland Empire Health Plan

Audit Type: Medical Audit and State Supported Services **Review Period: 10/1/17-9/30/18**

MCPs are required to provide a CAP and respond to all documented deficiencies within 30 calendar days, unless an alternative timeframe is indicated in the letter. MCPs are required to submit the CAP via email in word format which will reduce turnaround time for DHCS to complete its review.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. For deficiencies that require long term corrective action or a period of time longer than 30 days to remedy or operationalize, the MCP must demonstrate it has taken remedial action and is making progress toward achieving an acceptable level of compliance. The MCP will be required to include the date when full compliance is expected to be achieved. Any policy and/or procedure submitted during the CAP process must also be sent to the MCP's Contract Manager for review and approval 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.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
4. Members' Rights				
4.1.1 Clinical Grievance Determinations **Finding:** The contract designates that	**Remediation Activity:** IEHP's Grievance & Appeals Department implemented a policy change to the Medi-Cal Policy Member Grievance (Complaint) Resolution System – Standard and Expedited	**Policy and Procedure:** Please refer to *Attachment 1 - 4.1.1-GRV Clinical Grievance*	The policy change was implemented effective January 1, 2019. This policy is submitted in draft	**02/14/19** – The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "MED_GRV 2", which has been amended to include that qualified health

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qualified health care professionals with clinical expertise in treating a member's condition or disease, such as physicians, shall review grievances involving clinical matters to ensure an appropriate level of review. Poor member health outcomes may unintentionally result if clinical quality problems are not recognized and corrective actions prescribed. **Recommendation:** Revise and implement Plan policy and processes so that qualified health care professionals with clinical expertise in treating a member's condition or disease	MED_GRV 2 to implement a Medical Director Review requirement for all grievances involving clinical matters to ensure an appropriate level of review. This policy change was implemented effective January 1, 2019. To align the Medi-Cal and Medicare policies, a slight adjustment was made to the Medi-Cal policy. This policy is submitted in draft form and is pending approval through IEHP's Policy Review Committee on February 26, 2019. **Process Change:** Any clinical or service-related issue that potentially constitutes a Quality of Care (QOC) is initially coded as a QOC issue. Qualified health care professionals with clinical expertise in treating the Member's condition or disease make the final determination for all clinical grievances. All grievances involving clinical	*Determinations*, pages 1 and 2, which were revised to implement a Medical Director Review requirement for all grievances involving clinical matters. **Training:** IEHP's Grievance & Appeals Department was issued a Memorandum pertaining to the process change for submission of all grievances involving clinical matters to a Medical Director for initial categorization and final review	form and is pending approval through IEHP's Policy Review Committee on February 26, 2019. The process change was implemented on January 29, 2019.	care professionals with clinical expertise on the Member's condition or disease make the final determination for all clinical grievances. All cases that are potential QOC issues are submitted to IEHP Medical Director (page 1-2). **05/15/19** – The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding: - QOC Memorandum 2/15/19 that was issued to Grievance Team Members regarding the process change for submitting grievances with clinical matters to a Medical Director for initial categorization and final review. - QOC Subtask and MHK Grievance QOC Case Screenshot Walkthrough demonstrates evidence that Medical Directors are conducting initial reviews of

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(such as medical doctors) make the final determination for all clinical grievances.	matters are submitted to an IEHP Medical Director for an initial review to ensure an appropriate level of review. A determination is made to continue the case as a Quality of Care grievance or modify the case to a Quality of Service or other appropriate grievance case category. Upon conclusion of the grievance investigation, Quality of Care grievances are submitted to an IEHP Medical Director for final review. IEHP's Medical Director conducts a final case review and recommends corrective action as appropriate. This process change was implemented on January 29, 2019. **<u>Quality Assurance:</u>** All initial reviews of grievances involving clinical matters are submitted via email to IEHP's Medical Directors for review and response. This correspondence is added as a	to ensure an appropriate level of review.		grievances involving clinical matters. **This finding is closed.**

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	case note in the Plan's electronic case tracking system, MedHok. All final reviews of grievances involving clinical matters are submitted via subtask through the Plan's electronic case tracking system.			

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4.1.2 Misclassified Grievances **<u>Finding:</u>** Not properly classifying member dissatisfaction as grievances may result in the Plan not identifying and addressing potential access and quality of care issues. **<u>Recommendation:</u>** Implement the Plan's policy and monitor the new Member Service Representative process to ensure all oral expressions of dissatisfactions are classified as a grievance.	**<u>Remediation Activity:</u>** IEHP conducted grievance training for all Member Service Representative (MSR) staff in order for Team Members to appropriately identify oral expressions of dissatisfaction through the classification of standard, declined, and exempt grievances. Training for all MSR staff was completed on December 20, 2018. Please reference the training materials: *Attachment 2 - Member Grievance Resolution Training Process*, *Attachment 3 - Member Grievance Resolution Training Process- Member Rights*, and *Attachment 4 - Member Grievance Resolution Training Process- Categorization.* **<u>Process Change:</u>** *Review Member Rights* – The prior process required MSRs to transfer standard grievances to the Grievance and Appeals (G&A) Department. Therefore,	**<u>Job Aids:</u>** All relevant Member Services job aids were revised and updated on January 9, 2019 to include additional clarity on grievance identification, routing and resolution. *Please refer to Attachment 5 - Grievance and Appeals Job Aid Medi-Cal*. **<u>Training:</u>** The prior Grievance training was thoroughly reviewed and updated. Updates were made to training materials,	Job Aids were updated on January 9, 2019. Training was completed on December 20, 2018.	**02/14/19** – The following documentation supports the MCP's efforts to correct this finding: - Training materials, "Member Grievance Resolution Training Process", "Member Grievance Resolution Training Process – Member Rights", and "Member Grievance Resolution Training Process – Categorization" and sign in sheets as evidence that MSR staff was trained to identify oral expressions of dissatisfaction through the classification of standard, declined, and exempt grievances. - Job aids, "Grievance and Appeals Process" was updated to assist MSRs in identifying and routing grievances. - Grievance Resolution Process Training Decision Tree describes the process flow for correct routing and

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	the prior process did not require the MSR to review the Member rights with the Member. The new process requires MSRs to inform the Member of their right to file a grievance and to route a standard grievance to the G&A Department. *Declined Grievances* – The prior process required MSRs to classify declined grievances as a standard grievance and transfer to the G&A Department for follow up. The new process requires MSRs to classify the event as a declined grievance, and if needed, route the outstanding issue(s) to the appropriate departments for resolution. Declined grievances will be tracked and trended through the Grievance and Appeals Resolution Committee (GARC). *Identification of Potential Grievance* – The prior process required MSR staff to place a clarifying follow up call to the	training curriculum, job aids, process flows, decision trees and sample cases. Please refer to *Attachment 6 - IEHP Grievance Resolution Process-Training Decision Tree*. Trainings were conducted to address the oral expression of dissatisfaction, classification, categorization and routing. On December 20, 2018, Grievance training was completed for all Member Services staff. Please refer to *Attachment 7 -*		identification of grievances. - Exempt and Declined Grievance Forms are used for conducting focused audits by IEHP Member Services Quality Assurance team on exempt and declined grievances to ensure proper grievance classification. **This finding is closed.**

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	Member if a Quality Assurance (QA) representative identified a potential grievance was missed during the initial call. This process was not effective due to the low Member contact rate which delayed compliance on processing the standard grievance. The new process requires the MSR who handled the initial call to classify the event as a standard grievance and forward to the G&A Department for resolution. **<u>Quality Assurance:</u>** Based on the findings, the Member Services Quality Assurance team implemented additional focused audits on exempt and declined grievances to ensure accurate grievance classification. The Member Services Quality Assurance team is performing focused audits on 5%, an average daily volume of 283, of identified exempt grievances. The exempt grievance focused	*Member Services Grievance Training Sign-In Sheet- 1-2*. The Member Services staff was trained to classify an event as a standard grievance and forward the event to the G&A Department for resolution, if the issue was not fully resolved to the Member's satisfaction at the time of the phone call or by the close of the next business day. The training also served as a reminder to categorize resolved		

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	audit will be incorporated into IEHP's Ongoing Random Inbound Quality Assurance Audit once the department meets a 90% goal of exempt grievance classification. In February 2019, the Member Services Quality Assurance team started performing focused audits on 5%, an average daily volume of 181, of identified declined grievances. The declined grievance focused audit will be incorporated into IEHP's Ongoing Random Inbound Quality Assurance Audit once the department meets a 90% goal of declined grievance classification. As a part of IEHP's Ongoing Random Inbound Quality Assurance Audit, a minimum of 1% of inbound calls are audited to determine if the calls were handled correctly, including exempt and declined grievances. On average, Member Services handles	grievances as an exempt grievance within the MediTrac system, in addition to the appropriate documentation, when resolved at the time of the phone call or by the close of the next business day.		

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	105,000 calls per month. Please refer to *Attachment 8 - Exempt Grievance Audit Form* and *Attachment 9 - Declined Grievance Form*.			

Submitted by: **Date:**
Title: Chief Executive Officer