MEDICAL REVIEW BRANCH – ONTARIO
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

INLAND EMPIRE HEALTH PLAN

Contract Number: **04-35765 A10**

Audit Period: October 1, 2015
Through
September 30, 2016

Report Issued: April 10, 2017

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I. INTRODUCTION

Inland Empire Health Plan (IEHP or the Plan) was established on July 26, 1994 as the Local Initiative, Medi-Cal Managed Care Health Plan in the Inland Empire. The Plan received its Knox-Keene license on July 22, 1996 and commenced operations on September 1, 1996.

Inland Empire Health Plan is located in Rancho Cucamonga. The Plan is a Public Entity, formed as a Joint Powers Agency, and a not-for-profit health plan. IEHP was created by San Bernardino and Riverside counties as a Two-Plan Medi-Cal Managed Care model and provides managed care health services to Medi-Cal beneficiaries under the provision of Welfare and Institution Code, Section 14087.3.

Inland Empire Health Plan provides health care coverage to eligible members in San Bernardino and Riverside counties for which it is licensed as a mixed model Health Maintenance Organization (HMO). IEHP contracts with 18 Independent Physician Associations (IPAs) and 29 hospitals. The Plan also directly contracts with 494 Primary Care Physicians (PCPs) and 1,143 Specialists.

As of September 30, 2016 Inland Empire Health Plan's enrollment for Medi-Cal, Cal MediConnect, and Healthy Kids was approximately 1,241,541. Enrollment by product line was as follows:

Program	Membership	Percentage of Business
Medi-Cal (Including SPDs)	1,219,001	98.19%
Cal MediConnect	21,767	1.75%
Healthy Kids	773	0.06%
TOTAL	**1,241,541**	**100.00%**

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of October 1, 2015 through September 30, 2016. The on-site review was conducted from October 17, 2016 through October 21, 2016. The audit consisted of document review, verification studies, and interviews with Inland Empire Health Plan (IEHP or the Plan) personnel.

An Exit Conference was held on February 22, 2017 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. The Plan submitted supplemental information after the Exit Conference and it is reflected in this report.

The audit evaluated six categories of performance: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit report issued February 29, 2016 (for audit period of October 1, 2014 through September 30, 2015) identified deficiencies that were addressed in the Corrective Action Plan (CAP). The CAP response letter dated July 25, 2016 noted that previous audit findings were closed.

The summary of the findings by category follows:

Category 1 – Utilization Management

No findings were noted during this audit period.

Category 2 – Case Management and Coordination of Care

The Plan submitted a CAP to address the prior year audit findings. The Plan improved its monitoring procedures to ensure new members receive comprehensive IHAs within the required time frame. No findings were noted during this audit period.

Category 3 – Access and Availability of Care

The Plan submitted a CAP to address the prior year audit findings. The Plan recalibrated its claim processing system to ensure claims were reimbursed timely. In addition, the Plan developed audit tools and retrained its staff to ensure misdirected claims were properly forwarded to the appropriate providers. No findings were noted during this audit period.

Category 4 – Member's Rights

The Plan submitted a CAP to address the prior year audit findings. The Plan improved its monitoring system to properly report security incidents. No findings were noted during this audit period.

Category 5 – Quality Management

The Plan submitted a CAP to address the prior year audit findings. The Plan updated its policies and procedures and trained the appropriate staff. No findings were noted during this audit period.

Category 6 – Administrative and Organizational Capacity

The Plan's policies and procedures did not meet the requirement to notify DHCS within 10 working days of removing a suspended, excluded, or terminated provider from its provider network and confirm the provider is no longer receiving payments. During the on-site, the Plan submitted revised policies and procedures with the complete required contract language. However, the revised policies and procedures are awaiting approval from Managed Care Quality and Monitoring Division.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the Department of Health Care Services (DHCS), Medical Review Branch to ascertain that medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's Two-Plan Contract.

The audit evaluated six categories of performance: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

PROCEDURE

The on-site review of the Inland Empire Health Plan (IEHP) was conducted from October 17, 2016 through October 21, 2016. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of those policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: Fifteen (15) medical and ten (10) pharmacy prior authorizations requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Appeals Process: Ten (10) prior authorization appeal requests were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Initial Health Assessment: Twenty-eight (28) medical records were reviewed for completeness and timely completion.

Category 3 – Access and Availability of Care

Appointment Availability: Fifteen (15) contracted providers from the Provider's Directory were reviewed for accuracy, completeness, and appointment availability. The third next available appointment was used to measure access to care.

Emergency Service Claims: Nineteen (19) emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: Thirteen (13) family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights
Grievance Procedures: Twenty-five (25) grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Confidentiality Rights: Nine (9) cases were reviewed for proper reporting of all suspected and actual breaches to the appropriate entities within the required time frame.

Category 5 – Quality Management

New Provider Training: Ten (10) new contracted providers were reviewed for timely Medi-Cal Managed Care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse Reporting: Ten (10) cases were reviewed for proper reporting of all suspected fraud and/or abuse to the appropriate entities within the required time frame.

A description of the findings for each category is contained in the following report.

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.3 FRAUD AND ABUSE

Fraud and Abuse Reporting
Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse….

1) Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract.
2) Contractor shall provide effective training and education for the compliance officer and all employees.
3) Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines.
4) Fraud and Abuse Reporting—Contractor shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity….
5) Tracking Suspended Providers—Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs….
   2-Plan Contract E.2.26.B

SUMMARY OF FINDINGS:

6.3.1 Notification to Department Health Care Services (DHCS) of Excluded Providers

Title 42, Code of Federal Regulations, section 438.608 requires the Plan to implement and maintain procedures as well as a mandatory compliance plan that are designed to detect and prevent fraud, waste, and abuse. A compliance program that includes, at a minimum, the following elements: "…Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract and all applicable Federal and State requirements."

The Contract requires the Plan to "notify the Medi-Cal Managed Care Program/Program Integrity Unit within ten (10) State working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program." (Contract, Exhibit E, Attachment 2, (26)(B)(5))

In the prior year's audit findings, the Plan did not have specific written policies and procedures to notify DHCS within ten (10) working days of removing an excluded provider from its provider network and to confirm the provider is no longer receiving payment from the Medi-Cal program. As part of the Plan's Corrective Action Plan, policies and procedures were submitted to Managed Care Quality and Monitoring Division (MCQMD) to address the prior year's findings. Review of the policies and procedures during our

current audit revealed the Plan's policies did not clearly address the notification process to DHCS Medi-Cal Managed Care Program/Program Integrity Unit within ten (10) working days of removing a suspended, excluded, or terminated provider from its provider networks.

During the interview, the Plan stated they were unclear with the contract language as opposed to protocol and notification requirements specified in All Plan Letter 16-001. During the on-site, the Plan submitted revised policies and procedures (PRO_CMP 02r) that reflect the required contract language. However, this revised policy is awaiting approval from MCQMD.

Without clear written policies and procedures, the Plan cannot ensure notification to DHCS within the required timeframe of removing a suspended, excluded, or terminated provider from its provider network.

RECOMMENDATION:

6.3.1 Implement and maintain clear written policies and procedures to notify DHCS within ten (10) working days of removing an excluded provider from its provider network and confirm the provider is no longer receiving payments from the Medi-Cal program.

MEDICAL REVIEW BRANCH – ONTARIO
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

INLAND EMPIRE HEALTH PLAN

Contract Number:	**03-75797** State Supported Services
Audit Period:	October 1, 2015 Through September 30, 2016
Report Issued:	April 10, 2017

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INTRODUCTION

This report presents the audit findings of Inland Empire Health Plan's (IEHP or the Plan) State Supported Services under Contract No. 03-75797. The State Supported Services contract covers abortion services for IEHP.

The on-site audit was conducted from October 17, 2016 through October 21, 2016. The audit period was October 1, 2015 through September 30, 2016 and consisted of document review and interviews with Plan personnel.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Inland Empire Health Plan	
AUDIT PERIOD: October 1, 2015 through September 30, 2016	DATE OF AUDIT: October 17, 2016 through October 21, 2016

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

Abortion
Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:
Current Procedural Coding System Codes: 59840 through 59857*
HCFA Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, Z0336*

**These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.*
State Supported Services Contract Exhibit A.1

SUMMARY OF FINDINGS:

The Contract requires the Plan to provide State Supported Services. "State Supported Services means: Current Procedural Terminology Codes 59840 through 59857 and HCFA Common Procedure Coding System Codes X1516, X1518, X7724, X7726, and Z0336. These codes are subject to change upon DHS' implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract." *(Contract, Exhibit E, (10)(B))*

Policy and Procedure: *OPS/CLM P-13 State Supported Services Abortion*, states "Abortion is covered by the Medi-Cal program as a physician service. Abortion is by definition a sensitive service. Members have the right to access sensitive services through a contracted or non-contracted qualified provider. The service is generally rendered on an outpatient basis..." Also, Abortion includes updated "Correct Procedural Terminology (CPT) codes 59840, 59841, 59850-59852 and 59855-59857 and Healthcare Common Procedural Coding System (HCPCS) codes S0199, S0190 and S0191 identify elective abortion claims. All abortion services and related supplies do not require prior authorization. However, if the abortion services require inpatient confinement, the inpatient facility portion requires authorization."

Policy and Procedure: *MED_QM4.j Access to Sensitive Services,* states*, "…*abortion services for minors of any age may be obtained without parental/guardian consent."

Policy and Procedure: *MC_09E Access Standards Access to Sensitive Services,* states*, "*Treatment of sensitive services for minors may be obtained without parental consent through a practitioner other than the Primary Care Physician (PCP) if so requested and consistent with other access policies and procedures. Members, regardless of age, may obtain information regarding access to care and assistance with appointment scheduling for sensitive services through IEHP Member Services or their PCP's office…"

Policy and Procedure: *MC-14A Utilization Management Delegation and Monitoring*, states, "Prior authorization is not required for the following services:…Abortion Services".

The Plan informs members of State Supported Services accessibility and rights through the Member Handbook. Medi-Cal members can obtain abortion services from any qualified contracted or non-contracted provider without prior authorization. Minors of any age can get an abortion without permission from their parent or guardian.

During the interview, the Plan stated its Claim Configuration Department ensured that sensitive services billing codes are up to date. The Plan's claim payment process (Diamond System) waives prior authorization requirements for sensitive services.

The Plan complied with contractual requirements.

RECOMMENDATIONS:

None