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, 2016
Through
September 30, 2017

Report Issued: February 9, 2018

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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, California. 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 19 Independent Physician Associations (IPAs) and 27 hospitals. The Plan also directly contracts with 1,212 Primary Care Physicians (PCPs) and 2,232 Specialists.

As of September 30, 2017 Inland Empire Health Plan's enrollment for Medi-Cal and Cal MediConnect was 1,244,923. Enrollment by product line was as follows:

Program	Membership	Percentage of Business
Medi-Cal	1,219,777	97.98%
Cal MediConnect	25,146	2.02%
TOTAL	1,244,923	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, 2016 through September 30, 2017. The on-site review was conducted from October 16, 2017 through October 20, 2017.

An exit conference was held on January 18, 2018 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 finding. No supplemental information was provided after the Exit Conference.

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 April 10, 2017 (for audit period of October 1, 2015 through September 30, 2016) identified a deficiency under Category 6 that was addressed in the Corrective Action Plan (CAP). The CAP response letter dated May 8, 2017 noted that the previous audit finding was closed.

The summary of findings by category are as follows:

Category 1 – Utilization Management

No findings were noted during this audit period. The Plan continues to ensure timeliness of prior authorization and appeal requests, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Category 2 – Case Management and Coordination of Care

No findings were noted during this audit period. The Plan continues to improve its process to ensure new members receive comprehensive IHAs within the required time frame.

Category 3 – Access and Availability of Care

Although the Plan has a policy regarding waiting times in providers' offices, the Plan does not have procedures to monitor waiting times.

Category 4 – Member's Rights

No findings were noted during this audit period. The Plan continues to properly report security incidents within the required time frame.

Category 5 – Quality Management

No findings were noted during this audit period. The Plan continues to monitor, evaluate, and improve the quality of care and quality of services provided to its members.

Category 6 – Administrative and Organizational Capacity

The Plan submitted a CAP to address the prior year audit finding. The Plan updated its policies and procedures with required contract language. The Plan improved its tracking of suspended providers to ensure suspended and ineligible providers are removed from the Plan's network and reported to DHCS within 10 business days.

No findings were noted during this audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the Department of Health Care Services (DHCS), Medical Review Branch to ascertain 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 16, 2017 through October 20, 2017. The audit included 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 Authorizations Requests: Ten (10) medical and eleven (11) 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

Complex Case Management: Ten (10) medical records were reviewed for evidence of continuous tracking, monitoring, and coordination of resources to members who received complex case management services.

Behavioral Health Treatment (BHT): Ten (10) behavioral health charts were reviewed for compliance with BHT provision requirements.

Initial Health Assessment: Ten (10) 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.

Category 4 – Member's Rights

Grievance Procedures: Twenty (20) grievances were reviewed for timely resolution, response to complaint, and submission to the appropriate level for review.

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 finding for Category 3 is contained in the following report.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Inland Empire Health Plan	
AUDIT PERIOD: October 1, 2016 through September 30, 2017	DATE OF AUDIT: October 16, 2017 through October 20, 2017

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

Appointment Procedures:
Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.
2-Plan Contract A.9.3.A

Members must be offered appointments within the following timeframes:
3) Non-urgent primary care appointments – within ten (10) business days of request;
4) Appointment with a specialist – within 15 business days of request;
2-Plan Contract A.9.4.B

Prenatal Care:
Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.
2-Plan Contract A.9.3.B

Monitoring of Waiting Times:
Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments…
2-Plan Contract A.9.3.C

SUMMARY OF FINDINGS:

3.1.1 **Monitoring of Waiting Times in the Providers' Offices**

The Contract requires the Plan to "develop, implement, and maintain a procedure to monitor waiting times in the providers' offices…" (Contract, Exhibit A, Attachment 9 (3) (C))

According to Policy and Procedure MC_09A, Access Standards, waiting time for scheduled appointments must not exceed sixty (60) minutes and when members are advised to "walk-in" for an appointment are to be seen within four (4) hours.

Although the Plan has a policy regarding waiting times in providers' offices, the Plan does not have a procedure to monitor waiting times. The Plan's Facility Site Review (FSR) and Medical Record Reviews (MRR) did not measure, evaluate, or assess waiting times in the provider's office. In addition, the Plan's FSR and MRR reports did not show studies completed for waiting times. During onsite interview, the Plan confirmed their lack of procedure and stated waiting times in the providers' offices were primarily tracked through member grievances.

Lack of monitoring procedures for waiting times in providers' offices may lead to delays in medically necessary treatments and may potentially affect member's health and well-being**.**

RECOMMENDATIONS:

Develop and implement procedures to monitor waiting times in providers' offices.