

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

INLAND EMPIRE HEALTH PLAN

Contract Number: **04-35765 A10**

Audit Period: October 1, 2014
Through
September 30, 2015

Report Issued: February 29, 2016

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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 a 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 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 59 Independent Physician Associations (IPAs) and 29 hospitals. The Plan also directly contracts with 513 Primary Care Physicians (PCPs) and 1,180 Specialists.

As of August 1, 2015 Inland Empire Health Plan's enrollment for Medi-Cal, Healthy Kids, Dual Eligible Special Need Plan (D-SNP), and Cal MediConnect was approximately 1,105,354. Enrollment by product line was as follows:

- Medi-Cal Members (Including SPDs) 1,080,999
- Healthy Kids 723
- D-SNP (Medicare) 1,135
- Cal MediConnect 22,497

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, 2014 through September 30, 2015. The on-site review was conducted from October 5, 2015 through October 16, 2015. The audit consisted of documents review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on February 9, 2016 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report finding. The Plan submitted supplemental information after the Exit Conference which 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 summary of the findings by category follows:

Category 1 – Utilization Management

The Plan complied with the requirements in this Category.

Category 2 – Case Management and Coordination of Care

The Plan did not ensure new members received Initial Health Assessments (IHAs) within 120 days following the date of enrollment.

The Plan did not ensure new members received comprehensive IHAs.

Category 3 – Access and Availability of Care

The Plan did not reimburse complete claims within 45 working days of receipt.

The Plan did not forward misdirected claims to the appropriate capitated provider within 10 working days of receipt.

Category 4 – Member's Rights

The Plan did not report security incidents within 72 hours of discovery.

The Plan did not report security incidents to the DHCS Contracting Officer and Information Security Officer.

The Plan did not submit the full investigation report within 10 working days after discovery of security incident.

The Plan did not submit the full investigation report to the DHCS Contracting Officer and Information Security Officer.

Category 5 – Quality Management

The Plan did not fully adhere to reporting requirements for serious quality deficiencies by not meeting the Medical Board of California guidelines.

Category 6 – Administrative and Organizational Capacity

The Plan did not ensure that potential fraud, waste, and abuse cases were reported to DHCS within 10 working days.

The Plan does not have a policy and procedure to notify DHCS within 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.

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.

PROCEDURE

The on-site audit of the Inland Empire Health Plan (IEHP) was conducted from October 5, 2015 through October 16, 2015. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies to determine that policies were implemented and effective. 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: 15 medical and 10 pharmacies prior authorizations were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Appeals Process: 15 appeal requests were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

California Children Services (CCS): 6 medical records were reviewed for evidence of coordination of care between the Plan and CCS providers.

Initial Health Assessment: 25 medical records were reviewed for completeness and timely completion.

Complex Case Management: 6 medical records were reviewed for evidence of continuous tracking and monitoring of members who received complex case management services.

Category 3 – Access and Availability of Care

Appointment Availability: 15 contracted providers from the Provider's Directory were reviewed for accuracy, completeness, and appointment availability.

Emergency Service Claims: 28 emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: 22 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member’s Rights

Grievance Procedures: 25 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Confidentiality Rights: 11 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: 10 new contracted providers were reviewed for timely Medi-Cal Managed Care program training.

Credentialing: 6 Medical Board of California 805 reports were reviewed for timeliness and completeness.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse Reporting: 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.

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.4

INITIAL HEALTH ASSESSMENT

Provision of Initial Health Assessment:

Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22, CCR, Sections 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.

2-Plan Contract A.10.3.A

Provision of IHA for Members under Age 21

For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.

For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.

2-Plan Contract A.10.5

IHAs for Adults, Age 21 and older

- 1) Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.
- 2) Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes, but is not limited to:
 - a) blood pressure,
 - b) height and weight,
 - c) total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,
 - d) clinical breast examination for women over 40,
 - e) mammogram for women age 50 and over,
 - f) Pap smear (or arrangements made for performance) on all women determined to be sexually active,
 - g) chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,
 - h) screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and,
 - i) health education behavioral risk assessment.

2-Plan Contract A.10.6

Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement.

2-Plan Contract A.10.3.D

SUMMARY OF FINDINGS:

2.4.1 Timely Completion of Initial Health Assessment (IHA)

The Plan is required to “ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22 CCR Section 53851(b)(1) to each new Member within timelines stipulated...”
(Contract, Exhibit A, Attachment 10 (3)(A))

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The Plan is also required to “make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor’s unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement.” *(Contract, Exhibit A, Attachment 10 (3)(D))*

All Plan Letter states, “All new Plan members must have a complete IHA within 120 calendar days of enrollment.” *(MMCD Policy Letter 08-003)*

Although the Plan has policies and procedures that are consistent with the contract, the verification study revealed the IHAs were not completed within the 120 days following the date of enrollment in five medical records.

2.4.2 Comprehensive Initial Health Assessment

The Plan’s IHA shall “consists of a history and physical examination and Individual Health Education Behavioral Assessment (IHEBA) that enables a provider of primary care services to comprehensively assess Member’s current acute, chronic and preventative health needs...” *(Contract, Exhibit A, Attachment 10 (3))*

The Plan shall “ensure that the IHA includes an IHEBA as described in Exhibit A, Attachment 10, Provision 8, Paragraph A, 10, using an age appropriate DHCS approved assessment tool...” *(Contract, Exhibit A, Attachment 10 (3)(B))*

All Plan Letter states, “New members must complete the SHA (Staying Healthy Assessment) within the 120 days of the effective date of enrollment as part of the IHA.” *(MMCD Policy Letter 13-001)*

All Plan Letter states, “An age-specific IHEBA must be administered as part of the IHA.” *(MMCD Policy Letter 08-003)*

During the interview, the Plan stated they use the DHCS audit spreadsheet which consists of Member’s enrollment information, Primary Care Physician’s information, IHA completion date, and procedure code fields for tracking IHAs. The Plan did not monitor the procedure code field as an indicator to verify IHA completion.

The verification study revealed that 19 medical records did not include all the required components of a comprehensive IHA.

RECOMMENDATIONS:

Implement monitoring procedures to properly ensure:

- 2.4.1 New members receive IHAs within 120 calendar days of enrollment.
- 2.4.2 New members receive comprehensive IHAs.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.5

EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

Emergency Service Providers (Claims):

Contractor is responsible for coverage and payment of Emergency Services and post stabilization care services and must cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the plan.

2-Plan Contract A.8.13.A

Contractor shall pay for emergency services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the emergency medical condition including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the Member is stabilized sufficiently to permit discharge....

2-Plan Contract A.8.13.C

At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for Physician services at the lowest level of emergency department evaluation and management Physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

2-Plan Contract A.8.13.D

For all other non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan emergency services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with Provision 5, Claims Processing, and 42 USC Section 1396u-2(b)(2)(D). 3

2-Plan Contract A.8.13.E

Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR, Section 1300.67(g) and Title 22 CCR Section 53216.

2-Plan Contract A.9.7.A

Family Planning (Claims):

Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate....(as required by Contract)

2-Plan Contract A.8.9

Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this section...Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.36.

2-Plan Contract A.8.5

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h). CCR, Title 28, Section 1300.71(g)

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SUMMARY OF FINDINGS:

3.5.1 Timely Reimbursement of Complete Claims

The Plan is required to pay all claims submitted by contracting providers. In addition, the Plan is required to comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and with Health and Safety Code Sections 1371 through 1371.36 which states “reimburse each complete claim, or portion thereof, whether in state or out of state...but no later than 45 working days after the date of receipt of the complete claim by the Plan...” (*Contract, Exhibit A, Attachment 8 (5)(A)*)

Policy and Procedure: *MC_20A, Claims Processing*, states “claims for contracted providers must be paid or denied within 45 working days, or within other contractual timeframes.”

The verification study showed the Plan did not reimburse five Emergency Room (ER) claims and one Family Planning (FP) claims within 45 working days after the date of receipt.

3.5.2 Timely Forwarding of Claims to Appropriate Providers

The Plan is required to “maintain sufficient claims processing/tracking/payment systems capability to: comply with applicable State and Federal law, regulations and Contract requirements, determine the status of received claims, and calculate the estimate for incurred and unreported claims, as specified by Title 28, CCR, Sections 1300.77.1 and 1300.77.2.” (*Contract, Exhibit A, Attachment 8 (5)(D)*)

The Plan is required “to forward the claim to the appropriate capitated provider within 10 working days of the receipt of the claim that was incorrectly sent to the Plan.” (*CCR, Title 28, Section 1300.71(b)(2)(A)*)

Policy and Procedure: *OPS/CLM P-05, Misdirected Claims*, states “In the event IEHP receives a claim in error for services whose payment is subcontracted to a Capitated Hospital or IPA (Misdirected Claim), the claim will be redirected to the appropriate financially responsible entity within 10-working days from the receipt date.”

The verification study showed the Plan did not forward five misdirected claims to the appropriate capitated providers within 10 working days of receipt.

RECOMMENDATIONS:

3.5.1 Ensure complete claims are reimbursed within 45 working days of receipt.

3.5.2 Ensure misdirected claims are forwarded to the appropriate providers within 10 working days of receipt.

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CATEGORY 4 – MEMBER’S RIGHTS

4.3

CONFIDENTIALITY RIGHTS

Members’ Right to Confidentiality

Contractor shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

- 1) Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the network.
- 2) Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain Member's consent prior to release of confidential information, unless such consent is not required pursuant to Title 22 CCR Section 51009.

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:

Safeguards. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316. Business Associate shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Business Associate will provide DHCS with its current and updated policies.

Breaches and Security Incidents. During the term of this Agreement, Business Associate agrees to implement

1. **Notice to DHCS.** (1) To notify DHCS **immediately by telephone call plus email or fax** upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. (2) To notify DHCS **within 24 hours by email or fax** of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.
2. **Investigation and Investigation Report .** To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated “DHCS Privacy Incident Report” containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:
3. **Complete Report.** To provide a complete (full) report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure.

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SUMMARY OF FINDINGS:

4.3.1 Timely Reporting of Security Incidents

The Plan is required “to immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, to notify the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer...” (*Contract, Exhibit G, 3(H)(2)*)

The verification study revealed in three cases, the Plan did not report security incidents within 72 hours of discovery. During the audit period, the Plan did not have a monitoring system to properly report security incidents in a timely manner.

4.3.2 Reporting of Security Incidents to DHCS Officers

The Plan is required “to immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, to notify the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer...” (*Contract, Exhibit G, 3(H)(2)*)

The verification study revealed in 10 security incidents, the Plan did not notify the DHCS Contracting Officer and Information Security Officer. The Plan only notified the DHCS Privacy Officer. During the audit period, the Plan did not have a monitoring system to properly notify all three DHCS officers.

This is a repeat finding

4.3.3 Timely Submission of the Full Investigation Report

All Plan Letter APL 09-14 states “A full investigative report is not required until 10 working days after discovery of the incident, which gives the entity two weeks to conduct an investigation.” (*APL 09-14*)

Policies and Procedures: *PRO_CMP 04n - Notification of Privacy Incident and Breach Risk Assessment and Reporting*, states “Breach notification for Medi-Cal Members is provided to the DHCS PO, DHCS ISO and DHCS CMs within ten (10) calendar days of discovery of the breach a final, completed PIR will be submitted to DHCS, unless an exception has been obtained from DHCS for additional time needed to complete investigation. PIR will include IEHP investigative findings and corrective action plans as applicable.”

The verification study revealed that in five cases, the Plan did not submit the full investigation report within 10 working days after discovery of security incident. During the audit period, the Plan did not have a monitoring system to issue a full investigation report in a timely manner.

4.3.4 Submission of the Full Investigation Report to DHCS Officers

All Plan Letters APL 06-001 and APL 06-005 state the Plan should “provide notice DHCS of any unauthorized disclosure PHI or any breach of data security, or intrusion. In addition, the Plan should simultaneously provide notice to their MMCD Contracting Officer and the DHCS Privacy Officer...”

Policies and Procedures *PRO_CMP 04n - Notification of Privacy Incident and Breach Risk Assessment and Reporting*, states “Breach notification for Medi-Cal Members is provided to the DHCS PO, DHCS ISO and DHCS CMs...”

The verification study revealed that in 11 cases, the Plan did not submit the full investigation report to the DHCS Contracting Officer and DHCS Information Security Officer. The Plan only submitted the full

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investigation report to the DHCS Privacy Officer. During the audit, the Plan did not have a monitoring system to issue a full investigation report to all three DHCS officers.

RECOMMENDATIONS:

Implement a monitoring and reporting system to properly ensure the Plan:

- 4.3.1 Reports security incidents within 72 hours of discovery.
- 4.3.2 Reports security incidents to the DHCS MMCD Contracting Officer, DHCS Privacy Officer, and DHCS Information Security Officer.
- 4.3.3 Submits a full investigation report within 10 working days after discovery of security incident.
- 4.3.4 Submits the full investigation report to the DHCS MMCD Contracting Officer, DHCS Privacy Officer, and DHCS Information Security Officer.

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CATEGORY 5 – QUALITY MANAGEMENT

5.2

PROVIDER QUALIFICATIONS

Credentialing and Re-credentialing:

Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of Physicians including Primary Care Physicians and specialists in accordance with the MMCD Policy Letter 02-03, Credentialing and Re-credentialing.

Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

2-Plan Contract A.4.12

Standards:

All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered....Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor’s provider network.

2-Plan Contract A.4.12.A

Medi-Cal Managed Care Provider Training:

Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations.

Contractor shall ensure that provider training relates to Medi- Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, provider, Member and/or other healthcare professionals. Contractor shall conduct training for all providers within ten (10) working days after the Contractor places a newly contracted provider on active status....

2-Plan Contract A.7.5

Delegated Credentialing:

Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with Provision 6, Delegation of Quality Improvement Activities...

2-Plan Contract A.4.12.B

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. Contractor shall implement and maintain a provider appeal process.

2-Plan Contract A.4.12.D

SUMMARY OF FINDINGS:

5.2.1 - Timely Filing of Reports to Appropriate Authorities

The Plan is required to “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...” (*Contract, Exhibit A Attachment 4 (12)(D)*)

Policy and Procedure: *Manual MC_05F – Credentialing and Recredentialing*, requires that, “IEHP complies with the reporting requirements of the Medical Board of California (MBOC), the Osteopathic Medical Board of California (OMBC), the California Board of Optometry (CBO), and National Practitioners Data Bank

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(NPDB) as required by law. IEHP also complies with the reporting requirements of the California Business and Professions Code and the Federal Health Care Quality Improvement Act regarding adverse credentialing actions. Practitioners are notified of the report and its contents in accordance with law.”

MBOC timeframe for reporting 805 events requires, “An 805 report must be filed within 15 days...” In addition, MBOC 805.01 reporting form states, “An 805.01 report is a mechanism in which peer review bodies are required to report a final decision or recommendation of certain actions being taken against a licensee after an investigation.”

During the audit period, the Plan did not properly file the MBOC 805 report within the 15 days reporting timeframe in four cases. In addition, one 805.01 report was not filed.

RECOMMENDATION:

- 5.2.1 Develop and implement a process to report serious quality deficiencies and adhere to the Medical Board of California reporting guidelines.

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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 Timely Reporting of Suspected Fraud and/or Abuse Cases

The Plan “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...” (*Contract, Exhibit E, Attachment 2 (26)(B)(4)*)

During the interview, the Plan stated that they did not report fraud and/or abuse cases within 10 working days due to staffing issues.

The verification study revealed that in five cases the Plan did not report the results of the preliminary investigation of suspected fraud and/or abuse cases to DHCS within 10 working days.

This is a repeat finding

6.3.2 Notification of Excluded Provider to DHCS

The Plan is required to “...notify the Medi-Cal Managed Care Program/Program Integrity Unit within 10 State working days of removing a suspended, excluded, or terminated provider from its provider network and

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confirm that the provider is no longer receiving payments in connection with the Medicaid program.” *(Contract, Exhibit E, Attachment 2, (26)(B)(5))*

The Plan does not have a policy and procedure to notify DHCS within 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.

RECOMMENDATIONS:

- 6.3.1 Ensure the Plan resolves its staffing issues and implement a monitoring system to report fraud and/or abuse cases to DHCS within 10 working days of the date the Plan first becomes aware of such activity.
- 6.3.2 Develop and implement policies and procedures to notify DHCS within 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.

MEDICAL REVIEW - ONTARIO SECTION IV
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

INLAND EMPIRE HEALTH PLAN

Contract Number: **03-75797**
State Supported
Services

Audit Period: October 1, 2014
Through
September 30, 2015

Report Issued: February 29, 2016

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INTRODUCTION

This report presents findings of the contract compliance audit of Inland Empire Health Plan (IEHP or the Plan) and its implementation of the State Supported Services contract with the State of California. The State Supported Services contract covers abortion services for IEHP.

The on-site audit was conducted from October 5, 2015 through October 16, 2015. The audit covered the review period from October 1, 2014 through September 30, 2015 and consisted of document review of materials supplied by the Plan.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Inland Empire Health Plan

AUDIT PERIOD: October 1, 2014 through September 30, 2015

DATE OF AUDIT: October 5, 2015 through October 16, 2015

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 Plan's is required 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 59812-59857, Diagnosis Codes 635. - 637.99 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."

The Plan provides Medi-Cal members abortion services from any qualified contracted or non-contracted provider without prior authorization. Minors of any age can get abortion without permission from parent/guardian. There were no deficiencies noted during the review of the Plan's State Supported Services.

RECOMMENDATIONS:

None