

CONTRACT AND ENROLLMENT REVIEW DIVISION
RANCHO CUCAMONGA
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

INLAND EMPIRE HEALTH PLAN

2022

Contract Number: 04-35765

Audit Period: August 1, 2021
Through
July 31, 2022

Dates of Audit: September 19, 2022
Through
September 30, 2022

Report Issued: February 01, 2023

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I. INTRODUCTION

Inland Empire Health Plan (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, in Riverside and San Bernardino Counties.

The Plan provides Managed Care health services to Medi-Cal beneficiaries under the provision of Welfare and Institutions Code, section 14087.3. The Plan is a public entity, formed as a Joint Powers Agency, and a not-for-profit health plan. The Plan is headquartered in Rancho Cucamonga, California, created by Riverside and San Bernardino Counties as a two-plan Medi-Cal Managed Care model.

The Plan provides health care coverage to eligible members in San Bernardino and Riverside Counties as a mixed model Health Maintenance Organization. The Plan's contracted provider network consists of approximately eight Independent Physician Associations and 36 hospitals. The Plan also directly contracts with 1,398 Primary Care Physicians and 2,594 specialists.

As of July 31, 2022, the Plan had a total enrollment of 1,567,013 members.

II. EXECUTIVE SUMMARY

This report presents the findings of the Department of Health Care Services (DHCS) medical audit of the Plan for the period August 1, 2021 through July 31, 2022. The audit was conducted from September 19, 2022 through September 30, 2022. The audit consisted of document review, verification studies, and interviews with Plan personnel and one delegated entity.

An Exit Conference was held on January 13, 2023. 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 a response to address the audit findings. The results of the DHCS evaluation of the Plans response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management (UM), 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 on February 18, 2022, (audit period October 1, 2019 through July 31, 2021) identified deficiencies incorporated in the Corrective Action Plan (CAP). The prior year CAP was not closed at the time of onsite; however, this year's audit included review of documents to determine implementation and effectiveness of the Plan's corrective actions.

The summary of findings follows:

Category 1 – Utilization Management

The Plan is required to ensure appropriate processes are used to review and approve the provision of medically necessary covered services. The Plan did not maintain procedures to ensure appropriate processes were used to approve provision of medically necessary covered services.

During the prior audit, the Plan inappropriately applied prior authorization requirements for preventive services. Review of the Plan's response to the CAP yielded no finding. The Plan updated policies and procedures to ensure preventive services are covered without prior-authorization.

During the prior audit, the Plan did not document the periodic review of its appeal system conducted by its governing body, public policy body, and officer. Review of the Plan's response to the CAP yielded no finding. The Plan maintained written logs compiled into an annual report and were reviewed by the governing board.

During the prior audit, the Plan did not ensure the name of the decision maker was identified within the appeal written notification letter. Review of the Plan's response to the CAP yielded no finding. The Plan updated their appeal written notification letter template to include the name of the decision maker.

Category 2 – Case Management and Coordination of Care

Audit of category two yielded no findings.

Category 3 – Access and Availability of Care

The Plan is required to ensure all network providers are enrolled in the Medi-Cal program, however the Plan did not ensure its network providers were enrolled.

During the prior audit, the Plan did not ensure Physician Certification Statement forms were provided and contained all required components. The prior year CAP was not closed for this finding. The Plan is working with the Managed Care Quality and Monitoring Division (MCQMD) to correct the deficiency addressed in the CAP.

During the prior audit, the Plan did not have a process in place to ensure its subcontracted transportation providers were enrolled in the Medi-Cal program. The prior year CAP was not closed for this finding. The Plan is working with MCQMD to correct the deficiency addressed in the CAP.

Category 4 – Member's Rights

The Plan is required to contain an explanation of their decision within the grievance resolution letters provided to members. However, the Plan's Quality of Care (QOC) grievance resolution letters did not contain an explanation of the Plan's decision.

During the prior audit, the Plan did not ensure member grievances were completely resolved due to a lack of response from its network providers. Review of the Plan's response to the CAP yielded no findings. The Plan developed and implemented new processes to monitor and track provider responses.

During the prior audit, the Plan did not ensure corrective actions were enacted when addressing needed improvements to the QOC delivered by its providers. Review of the Plan's response to the CAP yielded no findings. The Plan developed and implemented new processes to monitor and track provider responses.

Category 5 – Quality Management

Audit of category five yielded no findings.

During the prior audit, the Plan did not maintain adequate oversight of UM delegates. The Plan did not require delegates to report UM findings quarterly and did not monitor delegate reporting of underutilization. Review of the Plan's response to the CAP yielded no findings. The Plan updated policies and procedures to ensure delegate quarterly reporting of under and over utilization activities.

Category 6 – Administrative and Organizational Capacity

The Plan is required to promptly refer any potential Fraud, Waste, or Abuse (FWA) identified and report to DHCS, the results of its preliminary investigation within ten working days. The Plan did not report to DHCS the results of their preliminary investigations of potential FWA identified within ten working days.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted this audit of the Plan 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.

PROCEDURE

The audit was conducted from September 19, 2022 through September 30, 2022, for the audit period August 1, 2021 through July 31, 2022. 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 the effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan and delegated entity representatives.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 21 denied medical prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to members and providers.

Appeals Process: 20 upheld medical appeals were reviewed for appropriate and timely adjudication.

Delegated Prior Authorization Requests: 20 medical prior authorization denials were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to members and providers.

Category 2 – Case Management and Coordination of Care

Behavioral Health Treatment: Ten member files were reviewed to confirm coordination of care and fulfillment of behavioral health requirements.

Category 3 – Access and Availability of Care

Emergency Service and Family Planning Claims: 16 emergency service claims and 12 family planning claims were reviewed for appropriate and timely adjudication.

Non-Emergency Medical Transportation (NEMT): 22 records were reviewed to confirm compliance with NEMT requirements.

Non-Medical Transportation (NMT): 20 records were reviewed to confirm compliance with NMT requirements.

Category 4 – Member’s Rights

Grievance Procedures: 90 grievances (including 23 QOC, 55 quality of service, and 12 exempt) were reviewed for timely resolution, classification, appropriate response to complainant, and submission to appropriate level for review.

Category 5 – Quality Management

Quality Improvement System: 13 potential quality incident files were reviewed for proper decision-making and effective actions taken to address needed quality improvements.

Provider Qualifications: Ten new provider training records were reviewed for timeliness.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse Reporting: Ten cases were reviewed for proper reporting of suspected FWA to DHCS within the required time frame.

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

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Inland Empire Health Plan (IEHP)

AUDIT PERIOD: August 1, 2021 through July 31, 2022

DATES OF AUDIT: September 19, 2022 through September 30, 2022

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1	UTILIZATION MANAGEMENT PROGRAM
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1.1 Prior Authorization of Medically Necessary Services

The Plan shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of medically necessary covered services. (*Contract, Exhibit A, Attachment 5(1)*).

The Plan's Policy, MED_UM 4.q *Referral and Pre-service Authorization Process* (revision date: 7/1/22), states the Plan has policies and procedures that ensure that decisions based on medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. Authorization of proposed or rendered services involve assessment of medical necessity and appropriateness of the level of care with determination of approval, denial, proposed service, or referral. The Plan and its delegates shall consistently apply criteria and standards for approving, partially approving, deferring, or denying requested services.

The Plan's, *Utilization Management Job Aid* (revision date: 1/2022), states in part that utilization data which includes approval and adverse decisions are reviewed and used to make decisions as to what services could be auto approved to manage inventory and expedite the decision turnaround during the COVID-19 pandemic.

Finding: The Plan did not ensure appropriate processes were used to approve provision of medically necessary covered services.

Verification study of prior authorizations revealed the following procedures were auto-approved without verification of medical necessity:

- Chemical Peels were authorized for acne. The Plan's review criteria list chemical peels as cosmetic and not medically necessary. The Plan's auto-approval system authorized this procedure despite not meeting medical necessity criteria.
- Trigger point injections were auto-approved for Bell's palsy. The Plan's auto-approval system authorized this procedure without checking if patients attempted other conventional therapy to meet medical necessity.

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- Radiology procedures such as X-rays, MRIs, and CT Scans were auto-approved without review of medical necessity.
- Experimental plasma injections were authorized and later found to be erroneously authorized through the Plan’s auto-approval system.

Although the Plan’s policy states that authorization of proposed or rendered services involve an assessment of medical necessity, the Plan did not have procedures to ensure auto-approved services met medical necessity requirements.

During the interview the Plan explained the auto-approval system included procedures that were determined to have low denial percentages and that oversight included a review of UM reports and monitoring for upward trends.

Without ensuring medical necessity is met for approved procedures, there is potential of increased risk for patient harm and risk for potential FWA.

Recommendation: Revise and implement policies and develop procedures to ensure appropriate processes are used to review and approve the provision of medically necessary covered services.

❖ COMPLIANCE AUDIT FINDINGS ❖

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.8

NON-EMERGENCY MEDICAL TRANSPORTATION AND NON-MEDICAL TRANSPORTATION

3.8 Medi-Cal Enrollment of Network Transportation Providers

The Plan is required to ensure all network providers are enrolled in the Medi-Cal program. (*All Plan Letter (APL) 19-004*)

NEMT and NMT providers must comply with the enrollment requirements set forth in APL 19-004 or any superseding APL. Managed Care Plans (MCP) may allow NEMT and NMT providers to participate in its network for up to 120 days, pending the outcome of the enrollment process. However, a MCP must terminate its contract with an NEMT or NMT provider upon notification from DHCS that the provider has been denied enrollment in the Medi-Cal program or upon expiration of the 120-day period. MCPs must have a process in place to track the 120-day timeframe for contracted NEMT and NMT providers with pending applications to ensure the contracts do not exceed 120 days. (*APL 22-008*)

The Plan's policy, *Pro Con 08 Processing Agreements for Prospective IEHP Direct Providers (revision date 1/1/2022)*, states in part that network providers are required to enroll in the Medi-Cal program and are allowed to participate in the network for up to 120 days pending the outcome of the DHCS enrollment screening process. The policy also states the Provider Network Team checks the Open Daily Portal to verify Medi-Cal enrollment. If a provider has been denied enrollment during the 120-day period, the provider will be terminated from the Plan's network.

Finding: The Plan did not ensure its network providers were enrolled in the Medi-Cal program.

The verification study revealed six network transportation providers were not enrolled in the Medi-Cal program while providing transportation services to Medi-Cal beneficiaries.

Although the Plan's policy states that network providers are required to enroll in the Medi-Cal program, the Plan did not adhere to its policy. The Plan maintained a monitoring process to verify the outcome of pending enrollment applications. However, the Plan explained during the interview that despite awareness of the 120-day expiration period, non-enrolled providers remained contracted due to a shortage of drivers and a lack of transportation providers.

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Without network providers being enrolled in the Medi-Cal program, the Plan cannot ensure compliance with the necessary criteria required to service Medi-Cal beneficiaries. Non-compliance with enrollment criteria can potentially result in members receiving unsafe transportation services.

Recommendation: Implement and adhere to policy to ensure network providers are enrolled in the Medi-Cal program.

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CATEGORY 4 – MEMBER’S RIGHTS

4.1	GRIEVANCE SYSTEM
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4.1 Quality of Care Resolution Letters

The Plan is required to maintain a Member Grievance System in accordance with California Code of Regulations (CCR), Title 28, sections 1300.68 and 1300.68.01, CCR, Title 22, section 53858, and 42 Code of Federal Regulations, 438.402. (*Contract Exhibit A, Attachment 14(1)*)

The Plan’s grievance resolution and written response is required to contain a clear and concise explanation of the Plan’s decision. (*CCR, Title 28, section 1300.68(d)(3)*)

The Plan’s written resolution must contain a clear and concise explanation of the Plan’s decision. (*APL 21-011*)

The Plan’s Policy, *Med_Grv 2 Quality of Care Grievance (revision date: 6/1/22)*, states in part that QOC case outcomes are privileged as according to CA Evidence Code 1157, in which resolution letters contain a template response to inform the member their case has been resolved.

Finding: The Plan’s QOC grievance resolution letters did not contain an explanation of the Plan’s decision.

In 23 of 23 QOC grievances reviewed in the verification study, the explanation of the Plan’s decision was not contained within the grievance resolution letters. Even in cases where the Medical Director stated that no QOC deficiency was identified, the Plan’s QOC grievance resolution letters contained a template response that stated in part:

The Plan has reviewed your grievance, provider’s response, and all reports. California law, CA Evidence Code 1157, does not allow results of our review to be shared. However, please know that we will take any action needed to improve QOC. Your complaint about a “QOC” issue has been documented. Any future issues will also be addressed. Our goal is to provide the best care we can to all our members. Our grievance process is how we determine and fix any problems. Rest assured, the Plan takes proper action when a problem exists with a provider, a facility, or their staff.

As a result, members did not receive a clear explanation of the Plan’s final resolution. It was also noted the Plan’s template language was not accurate with regard to the investigation process. For example, the template states “The Plan has reviewed all

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reports”; yet, there were five cases in which provider responses were not submitted and thereby not actually reviewed.

During the onsite interview, the Plan acknowledged using template responses for resolution letters and stated this was done to avoid disclosing information considered to be confidential to the Plan as noted within their QOC grievance policy. However, a clear and concise explanation of the Plan’s decision is required, but does not have to include confidential information. Therefore, the Plan’s policy is not in compliance with APL and regulation requirements stated above.

Without a clear and concise explanation of the Plan’s final resolution of QOC grievances contained within resolution letters, members are unable to make fully informed decisions regarding their healthcare, which can lead to inappropriate choices and possible member harm.

Recommendation: Revise policy and implement procedures to ensure QOC grievance resolution letters include the explanation of the Plan’s decision.

❖ COMPLIANCE AUDIT FINDINGS ❖

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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.2

FRAUD AND ABUSE

6.2 Potential Fraud, Waste, and Abuse Reporting to DHCS

The Plan is required to promptly refer any potential FWA that is identified to the DHCS Audits and Investigations Intake Unit. The Plan is required to conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected FWA within ten working days of the date the contractor first becomes aware of, or is on notice of, such activity. (*Contract, Exhibit E, Attachment 2(26)(B)(7)*)

The Plan's policy, *PRO_CMP F-01 Fraud and Abuse Program Description 2022 (effective date: 1/2022)*, states the Plan shall report to DHCS all cases of potential FWA, where there is reason to believe that an incident of FWA has occurred by subcontractors, members, providers or team members within ten working days of the date when the Plan first becomes aware of or is on notice of such activity.

The Plan's policy, *PRO_CMP F-02 FWA Program – Regulatory Reporting Procedures 2022 (revision date: 1/1/21)*, states when reporting FWA involving the Medi-Cal program, a Compliance Special Investigations Unit team member will conduct, complete, and report the results of a preliminary investigation of the suspected FWA by submitting a Confidential Medi-Cal Complaint Report (MC 609) to DHCS within ten business days of the date when the Plan first becomes aware of, or is on notice of, such activity.

Finding: The Plan did not report to DHCS the results of their preliminary investigations of potential FWA incidents identified within ten working days.

The Plan's FWA reporting process consisted of a preliminary and full investigation of reported allegations. Although, the Plan's policy states that results of their preliminary investigation of suspected FWA were to be submitted to DHCS within ten business days, the Plan did not follow its policy and did not report the results of their preliminary investigations to DHCS timely.

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Sample review of the Plan’s FWA reporting process during the audit period revealed the following:

- The Plan identified 33 cases as potential fraud after their preliminary investigation of reported allegations.
- The 33 identified cases were not reported to DHCS within ten working days.
- Of the 33 cases, the Plan eventually reported four cases to DHCS.

During the interview, the Plan explained that suspected fraud was only reported to DHCS when enough credible evidence had been obtained from a thorough investigation. As a result, cases submitted to DHCS did not consist of all potential fraud the Plan was aware of.

Failure to report all identified cases of potential FWA to DHCS timely, can limit the ability to track, analyze, and respond to the incidents to mitigate the impact to members, providers, the Plan, and the Medi-Cal program.

Recommendation: Implement policies and procedures to ensure prompt reporting of all potential FWA within ten working days of when the Plan first becomes aware of, or is on notice of, the activity.

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AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

**INLAND EMPIRE HEALTH PLAN
STATE SUPPORTED SERVICES**

2022

Contract Number: 03-75797

Audit Period: August 1, 2021
Through
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II. COMPLIANCE AUDIT FINDINGS2

I. INTRODUCTION

This report represents the result of the audit of Inland Empire Health Plan (Plan) State Supported Services Contract No. 03-75797. The State Supported Services Contract covers contracted abortion services with the Plan.

The audit was conducted from September 19, 2022 through September 30, 2022 for the audit period August 1, 2021 through July 31, 2022. The audit consisted of document review of materials supplied by the Plan, verification study, and interviews.

An Exit Conference with the Plan was held on January 13, 2023. There were no deficiencies found for the audit period on the Plan's State Supported Services.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Inland Empire Health Plan

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STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

The Plan agrees to provide, or arrange to provide, to eligible members the following State Supported Services: Current Procedural Coding System Codes 59840 through 59857 and Health Care Finance Administration Common Procedure Coding System Codes X1516, X1518, X7724, X7726, and Z0336. These codes are subject to change upon the Department of Health Care Services implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code sets provisions. (*Contract, Exhibit A, (1)*)

Plan Policy, *MC_9E Access to Services with Special Arrangements (revision date: 1/1/21)*, states abortion is covered by the Medi-Cal program as a physician service. Members have the right to access abortion services through a contracted or non-contracted qualified provider and services are generally rendered on an outpatient basis. Additionally, abortion services and related supplies do not require prior authorization. However, if the abortion services require inpatient hospitalization, the inpatient facility services (only) require authorization.

Review of the Plan's State Supported Services claims processing system and abortion services billing procedure codes yielded no findings for the audit period.

RECOMMENDATION: None.