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

REPORT ON THE MEDICAL AUDIT OF

INLAND EMPIRE HEALTH PLAN

2023

Contract Number:	04-35765
Audit Period:	August 1, 2022 Through July 31, 2023
Dates of Audit:	September 18, 2023 Through September 29, 2023
Report Issued:	January 5, 2024

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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 seven Independent Physician Associations and 34 hospitals. The Plan also directly contracts with 1,381 primary care physicians and 2,595 specialists.

As of July 31, 2023, the Plan had a total enrollment of 1,685,464 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 of August 1, 2022 through July 31, 2023. The audit was conducted from September 18, 2023 through September 29, 2023. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on December 6, 2023. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. On December 20, 2023, the Plan submitted a response to address the audit findings. The results of the DHCS evaluation of the Plan's 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 1, 2023, (audit period August 1, 2021 through July 31, 2022) identified deficiencies incorporated in the Corrective Action Plan (CAP). The prior year CAP was not closed at the time of audit; however, this year's audit reviewed the implementation and effectiveness of the Plan's proposed corrective actions.

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of findings by category follows:

Category 1 – Utilization Management

The Plan is required to 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. The Plan did not ensure continuous updates and improvements to the UM program to ensure the provision of medically necessary covered services.

The Plan is required to include within its UM program mechanisms to detect overutilization of Behavioral Health Treatment (BHT) services. The Plan's UM program did not have a mechanism to detect over utilization of BHT services.

Category 2 – Case Management and Coordination of Care

Review of Category 2 yielded no findings.

Category 3 – Access and Availability of Care

Review of Category 3 yielded no findings.

Category 4 – Member's Rights

The Plan's grievance resolution letters are required to contain a clear and concise explanation of the Plan's decision. The Plan's Quality of Care (QOC) grievance resolution letters did not contain an explanation of the Plan's decision.

Category 5 – Quality Management

Review of Category 5 yielded no findings.

Category 6 – Administrative and Organizational Capacity

Review of Category 6 yielded no findings.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted this audit of the Plan 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 audit was conducted from September 18, 2023 through September 29, 2023, for the audit period of August 1, 2022 through July 31, 2023. 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 personnel.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization (PA) Requests: 34 medical (28 standard and six urgent), nine pharmacy, and five Major Organ Transplant PA requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Appeal Process: Ten (five Seniors and Persons with Disabilities (SPD) and five non-SPD) PA appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

BHT: 12 medical records were reviewed for compliance with BHT requirements.

Category 3 – Access and Availability of Care

Emergency Service and Family Planning Claims: 24 emergency service claims, including four post-stabilization, and 35 family planning claims were reviewed for appropriate and timely adjudication.

Non-Emergency Medical Transportation (NEMT): 30 (five SPD) records were reviewed to confirm compliance with NEMT requirements.

Non-Medical Transportation (NMT): 25 records were reviewed to confirm compliance with NMT requirements.

Category 4 – Member's Rights

Grievance Procedures: 16 standard quality of service, three exempt quality of service, 27 standard QOC, nine SPD QOC, and ten exempt QOC grievance cases were reviewed for timely resolution, appropriate response to complainant, and submission to the appropriate level for review.

Category 5 – Quality Management

Quality Improvement System: Ten potential quality issue cases were reviewed for timely evaluation and effective action taken to address improvements.

Category 6 – Administrative and Organizational Capacity

Fraud, Waste, and Abuse: Ten fraud and abuse cases were reviewed for proper reporting of suspected fraud, waste, or abuse to DHCS within the required timeframe.

Encounter Data – Proposition 56: 36 claims were reviewed for proper reporting of complete, accurate, reasonable, and timely encounter data.

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

❖ COMPLIANCE AUDIT FINDINGS ❖
PLAN: Inland Empire Health Plan
AUDIT PERIOD: August 1, 2022 through July 31, 2023 **DATES OF AUDIT: September 18, 2023 through September 29, 2023**

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1	UTILIZATION MANAGEMENT PROGRAM

1.1.1 Utilization Management Program Updates and Improvements

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, *MC_14D Preservice Referral Authorization Process (revision date 1/1/2023),* states the Plan ensures decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes.

The Plan's policy, *MED_UM04CC Automated Authorizations (revision date 3/1/2023),* states as part of the weekly UM PA Clinical Quality Assurance Case Audit, UM staff will review a selection of auto-authorized services. UM clinical staff will review clinical documentation to ensure that services were authorized appropriately. UM clinical staff will flag any issues identified during their review, including if a service should be considered for removal from the auto-authorization process. Findings from these retrospective reviews are forwarded to a Senior Medical Director for review. If the service should be removed from the auto-authorization process, UM clinical staff will submit a request to update the rules to remove the service in question. Recommendations to add, remove, or otherwise revise auto-authorization rules are presented to the UM subcommittee for review and approval on a quarterly basis.

Finding: The Plan did not ensure continuous updates and improvements to the UM program to ensure the provision of medically necessary covered services.

A verification study of PAs revealed the following procedures were auto approved without an appropriate diagnosis for medical necessity.

- Biofeedback training of pelvic muscles was approved in three cases for upper extremity diagnoses.
- Gait training, walking exercises, were approved in three cases for upper extremity diagnoses.

During the interview, the Plan acknowledged potential overutilization of biofeedback training and conducted a focus review where 12 of 20 cases did not meet medical

necessity. The internal audit findings were discussed and documented in the July 2023, UM subcommittee meeting notes and no action was taken. The Plan did not follow internal policy. Physical therapy authorizations were the second highest category of approved PA, and the Plan was unaware that gait training was approved for upper extremity diagnosis and agreed that it was not appropriate despite being auto approved.

The Plan's quality improvement for its UM program is ineffective since the Plan did not implement its policies to conduct continuous improvement of issues identified through its monitoring process.

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

Recommendation: Revise and implement policies and procedures to ensure continuous updates and improvements are made to the UM program for the provision of medically necessary covered services.

1.1.2 Mechanisms to Detect Overutilization of Behavioral Health Treatment Services

The Plan shall include, within the UM program, mechanisms to detect both under and over utilization of health care services. *(Contract, Exhibit A, Attachment 5(5))*

For members under the age of 21, Plans are required to provide and cover, or arrange, as appropriate, all medically necessary Early and Periodic Screening, Diagnostic, and Treatment services, including BHT services, when they are covered under Medicaid, regardless of whether California's Medicaid State Plan covers such services for adults. Additionally, Plans must comply with mental health parity requirements when providing BHT services. *(All Plan Letter (APL) 19-014 Responsibilities for Behavioral Health Treatment Coverage for Members under the age of 21 (11/12/2019))*

The Plan's Policy, *Med_UM5.e Over and Under Utilization Tracking and Reporting Policy (revision date 6/1/22)*, states that the Plan has mechanisms to detect over and underutilization of services. The Plan collects, reports, and analyzes medical and behavioral health UM data for Medi-Cal members. Such data includes internally generated reports designed to assess and detect potential over and underutilization of services as well as individual UM trend reports. This policy also states that the UM subcommittee establishes measurable action plans (e.g., special audits) to more closely monitor physicians or providers that exceed the established standards and/or thresholds.

The Plan's Policy, *Guideline #UM_BH 08: Behavioral Health Treatment Authorization*

Guidelines (revision date 11/1/22), states the Plan will cover medically necessary BHT evaluation for eligible beneficiaries under the age of 21 years. The Plan's Policy, *IEHP Behavioral Health Manual Med_BH 1.a (revision date 8/1/2022),* states the UM behavioral health program does not impose quantitative or non-quantitative treatment limitations to its timelines and processes more stringently on plan-covered mental health and substance use disorder services than are imposed on medical/surgical services.

Finding: The Plan's UM program did not have a mechanism to detect over utilization of BHT services.

The Plan did not furnish documentation and/or reports supporting implementation of its policy to collect, report, and analyze behavioral health UM data for over utilization.

During the interview, the Plan acknowledged not having an effective mechanism to monitor for overutilization of BHT services since no quantity limits are placed if it does not exceed threshold guidelines when a member has a medical necessity diagnosis.

Without effective mechanisms to detect over utilization of BHT services, the Plan is unable to prevent possible fraud, waste, and abuse.

Recommendation: Develop and implement policies and procedures to ensure the Plan's UM program has an effective monitoring mechanism to detect overutilization of BHT services.

❖ COMPLIANCE AUDIT FINDINGS ❖
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CATEGORY 4 – MEMBER'S RIGHT

4.1	GRIEVANCE SYSTEM

4.1.1 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 Code of Federal Regulations (CFR), Title 42, section 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)*

Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the QOC or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the Managed Care Organization, Prepaid Inpatient Health Plan or Prepaid Ambulatory Health Plan to make an authorization decision. *(CFR, Title 42, section 438.400(b))*

Plan policy, *Med_Grv 2 Quality of Care Grievance (revision date: 1/1/23),* states members receive letters that contain clear and concise explanation of the Plan's decision. This policy cites the California Evidence Code section 1157 as the basis why QOC case outcomes are privileged and protected from disclosure, including grievance resolution letter disclosure.

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

The Plan did not implement its internal policy, nor did it comply with APL 21-011 requirements, per the verification study to determine compliance with grievance resolution requirements. One hundred percent of the verification samples, seven out of seven, of the QOC grievances did not contain specific details regarding the outcome of the QOC investigations. The Plan's template letter cited California Evidence Code

section 1157 as the basis for why details could not be shared. This was confirmed during the Plan interview.

During the interview, the Plan acknowledged using its revised template for grievance resolution letters that lacked an explanation of the Plan's final resolution addressing the member's grievance.

As a corrective action for the prior year's audit finding, 4.1 QOC Resolution Letters, the Plan made changes to its template letter in March 2023. However, the revised grievance resolution letter template still did not explain the Plan's final resolution to address the member's grievance. The Plan's template for grievance resolution letters incorrectly applied the Peer Review Protection under the California Evidence Code section 1157. California Evidence Code section 1157 does not apply to the provision of a clear and concise explanation of the Plan's decision in resolving the member's grievance. Section 1157 of the California Evidence Code protects proceedings and records of peer review bodies from discovery in formal court proceedings. Discovery refers to a formal exchange of evidentiary information between parties to a pending action before the Supreme Court, a court of appeal, or superior court (*Arnett v. Dal Cielo* (1996) 14 Cal.4th 4, 24). A grievance is not a proceeding before a superior court, nor does the grievance process contain a formal exchange of evidentiary information between parties (CFR, Title 42, section 438.400(b); *Arnett v. Dal Cielo, supra,* 14 Cal.4th at p. 24).

Without an explanation of the Plan's final decision of QOC grievances contained within resolution letters, members are unable to make well informed decisions regarding their healthcare, which can lead to inappropriate choices and possible member harm.

This is a repeat finding from the prior year 2022 annual DHCS audit, 4.1 Quality of Care Resolution Letters.

Recommendation: Revise and implement policies and procedures and grievance resolution template letters to ensure QOC grievance resolution letters include an explanation of the Plan's decision.

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RANCHO CUCAMONGA SECTION

REPORT ON THE MEDICAL AUDIT OF

INLAND EMPIRE HEALTH PLAN
STATE SUPPORTED SERVICES

2023

Contract Number: 03-75797

Audit Period: August 1, 2022
Through
July 31, 2023

Dates of Audit: September 18, 2023
Through
September 29, 2023

Report Issued: January 5, 2024

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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 abortion services with the Plan.

The audit was conducted from September 18, 2023 through September 29, 2023, for the audit period of August 1, 2022 through July 31, 2023. The audit consisted of document review of materials provided by the Plan, a verification study, and interviews with the Plan's administration and staff.

An Exit Conference with the Plan was held on December 6, 2023. There were no deficiencies found for the audit period of the Plan's State Supported Services.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Inland Empire Health Plan

AUDIT PERIOD: August 1, 2022 through July 31, 2023
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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_P-13 State Supported Services, Abortion (revision date: 1/1/22),* stated 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.