DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

RANCHO CUCAMONGA SECTION

REPORT ON THE MEDICAL AUDIT OF INLAND EMPIRE HEALTH PLAN FISCAL YEAR 2024-25

Contract Number(s): 04-35765 and 23-30225

Audit Period: August 1, 2023 — July 31, 2024

Dates of Audit: November 4, 2024 — November 15, 2024

Report Issued: March 28, 2025

TABLE OF CONTENTS

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 members under the provision of the California 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, and was 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 12 independent physician associates and 35 hospitals. The Plan also directly contracts with 1,393 primary care physicians and 2,708 specialists.

As of July 31, 2024, the Plan had a total enrollment of 1,510,641 members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of August 1, 2023, through July 31, 2024. The audit was conducted from November 4, 2024, through November 15, 2024. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on March 13, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On March 24, 2025 the Plan submitted a response after the Exit Conference. The evaluation results 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 for the period of August 1, 2022, through July 31, 2023, was issued on January 5, 2024. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation of the prior year 2023, Corrective Action Plan (CAP).

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

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan shall include, within the UM program, mechanisms to detect both under and overutilization of health care services including Behavioral Health Treatment (BHT) services. The Plan did not ensure the UM program had a mechanism to detect overutilization of BHT services.

Category 2 – Case Management and Coordination of Care

There were no findings noted for this category during the audit period.

Category 3 – Access and Availability of Care

There were no findings noted for this category during the audit period.

Category 4 – Member's Rights

There were no findings noted for this category during the audit period.

Category 5 – Quality Management

There were no findings noted for this category during the audit period.

Category 6 – Administrative and Organizational Capacity

There were no findings noted for this category during the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted the audit to ascertain that medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

DHCS conducted an audit of the Plan from November 4, 2024, through November 15, 2024, for the audit period of August 1, 2023, through July 31, 2024. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 36 verification studies were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Appeal Process: 30 Prior Authorization 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.

Enhanced Care Management: 16 medical records were reviewed for compliance with enhanced care management requirements.

Category 3 – Access and Availability of Care

Non-Emergency Medical Transportation (NEMT): 15 verification studies were reviewed to confirm compliance with NEMT requirements.

Non-Medical Transportation (NMT): 15 verification studies were reviewed to confirm compliance with NMT requirements.

Category 4 – Member's Rights

Grievance Procedures: 30 quality of care and 23 quality of service grievance cases were reviewed for timely resolution, appropriate response to the complainant, and submission to the appropriate level for review. Six exempt grievances, two expedited, and five calls were reviewed for proper classification and routing to the appropriate level for review.

Category 5 – Quality Management

Quality Improvement System: 17 potential quality issue cases were reviewed for timely evaluation and effective action taken to address improvements.

Provider Training: 15 new provider training records were reviewed for timeliness.

Category 6 – Administrative and Organizational Capacity

Fraud, Waste, and Abuse: 15 fraud and abuse cases were reviewed for proper reporting of suspected fraud, waste, and abuse to DHCS within the required timeframe.

Encounter Data/Proposition 56 Directed Payments: 15 claims were reviewed to verify if the Plan reported complete, accurate, reasonable, and timely encounter data.

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management

1.1 UTILIZATION MANAGEMENT PROGRAM

1.1.1 Mechanisms to Detect Overutilization of Behavioral Health Treatment Services

The Plan shall include, within the UM program, mechanisms to detect both over and underutilization of health care services including BHT services. *(Contract, Exhibit A, Attachment 3 Section 2.3.3A)*

Plan policy, *Med-UM5.e Over and Under Utilization Tracking and Reporting* (effective 02/01/2024), described how 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.

Finding: The Plan did not ensure the UM program had a mechanism to detect overutilization of BHT services.

Plan policy Med-UM5.e, states that the Plan maintains a mechanism to detect both over and underutilization of services. Although the policy specifies a mechanism to detect overutilization, the Plan did not effectively identify overutilization of BHT services during the audit period.

As a CAP to the prior audit deficiency *(1.1.2 Mechanisms to Detect Overutilization of Behavioral Health Treatment Services)* of the Plan's UM program not having a mechanism to detect overutilization of BHT services, the Plan implemented a new process to monitor overutilization of BHT services. This process required overutilization monitoring for BHT claims with more than the threshold of 40 hours of therapy sessions per week. In an interview, the Plan stated that implementation of this process occurred in May 2024, which was nine months into the audit period. Therefore, changes implemented, and documentation presented could not be completely assessed and validated at the time of this year's audit with the documentation presented. For the requirement that the Plan must establish mechanisms to detect overutilization of BHT services, non-compliance was identified during the audit period.

Without effective mechanisms to detect overutilization of BHT services, the Plan is unable to prevent possible fraud, waste, or abuse.

This is a repeat of the prior year finding – 1.1.2 Mechanisms to Detect Overutilization of Behavioral Health Treatment Services

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

DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

RANCHO CUCAMONGA SECTION

REPORT ON THE MEDICAL AUDIT OF INLAND EMPIRE HEALTH PLAN FISCAL YEAR 2024-25

Contract Number(s): 22-20463 and 23-30257

Contract Type: State Supported Services

Audit Period: August 1, 2023 — July 31, 2024

Dates of Audit: November 4, 2024 — November 15, 2024

Report Issued: March 28, 2025

TABLE OF CONTENTS

I. INTRODUCTION

This report presents the results of the audit of Inland Empire Health Plan (Plan) compliance and implementation of the State Supported Services contract numbers 22-20463 and 23-30257 with the State of California. The State Supported Services Contracts cover abortion services with the Plan.

The audit covered the period of August 1, 2023, through July 31, 2024. The audit was conducted from November 4, 2024, through November 15, 2024, which consisted of a document review and verification study with the Plan administration and staff.

An Exit Conference with the Plan was held on March 13, 2025. No deficiencies were noted during the review of the State Supported Services Contracts.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Plan is required to provide, or arrange to provide, to eligible members the following State Supported Services: Current Procedural Terminology Codes 59840 through 59857 and the Centers for Medicare and Medicaid Services 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. *(Contracts, Exhibit A*)

Plan policy, *Operations-Claims P-13* (effective 01/01/2024), stated abortion is covered by the Medi-Cal program as a physician service, regardless of gestational age of the fetus. Members have the right to access abortion services through a contracted or noncontracted qualified provider without prior authorization and are generally rendered on an outpatient basis. Abortion services and related supplies do not require prior authorization. However, if the abortion services require inpatient hospitalization, only the inpatient facility services require authorization.

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

Recommendation: None