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

REPORT ON THE MEDICAL AUDIT OF

INLAND EMPIRE HEALTH PLAN

Contract Number: **04-35765**

Audit Period: October 1, 2018
Through
September 30, 2019

Report Issued: January 8, 2020

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 beneficiaries under the provision of Welfare and Institutions Code, section 14087.3. The Plan is a public, non-profit Joint Powers Agency, Knox-Keene licensed 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 contracts with approximately 11 Independent Physician Associations and 33 hospitals. The Plan also directly contracts with 1,168 Primary Care Physicians and 2,285 Specialists.

As of September 2019, the Plan had a total enrollment of 1,217,317 Medi-Cal members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit of the Plan for the period of October 1, 2018 through September 30, 2019. The on-site review was conducted from October 7, 2019 through October 11, 2019. The audit consisted of document review, verification studies, and interviews with Plan personnel and delegated entity.

An Exit Conference was held on December 11, 2019. 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 did not submit any additional information.

The audit evaluated six categories of performance: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit report, for audit period October 1, 2017 through September 30, 2018, was issued January 17, 2019. The Corrective Action Plan (CAP) closeout letter was sent to the Plan on July 11, 2019. This year's audit examined documentation to determine the implementation and effectiveness of the Plan's CAP.

The summary of findings by category are as follows:

Category 1 – Utilization Management

Review of prior authorization and appeal requests for appropriate and timely adjudication yielded no findings.

The delegation oversight review of a delegated entity yielded no findings.

Category 2 – Case Management and Coordination of Care

The Plan did not notify members of the complete Continuity of Care (COC) transition process. The Plan did not ensure COC approval letters contained all the required information including transition of care at the end of the COC period and members' rights to choose a different provider from the Plan's network.

Category 3 – Access and Availability of Care

The Plan did not have procedures to monitor waiting times for providers to answer and return members' telephone calls.

Category 4 – Member's Rights

During the prior year audit, the Plan did not have a qualified health care professional with clinical expertise in treating members' condition or disease, to review grievances involving clinical matters. The Plan corrected the deficiency by implementing policies and procedures requiring that a Medical Director adjudicate all clinical grievances. This year's review yielded no audit findings.

During the prior year audit, the Plan did not classify all members' oral expressions of dissatisfaction as grievances during inquiry calls. The Plan corrected the deficiency by training Member Service Representatives to appropriately identify members' oral expressions of dissatisfaction by classifying them as grievances. This year's review yielded no audit findings.

When grievance resolution were not reached within 30 calendar days, the Plan did not have procedures to timely notify members of the grievance status and estimated completion date.

Category 5 – Quality Management

Review of the Plan's quality improvement and monitoring system yielded no findings.

Category 6 – Administrative and Organizational Capacity

Review of the Plan's organizational capacity to guard against fraud and abuse yielded no findings.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Medical Review Branch 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 onsite review was conducted from October 7, 2019 through October 11, 2019. 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 ten pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Appeals Process: 15 prior authorization appeals were reviewed for appropriate and timely adjudication.

Delegated Prior Authorization Requests: 15 medical prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Category 2 – Case Management and Coordination of Care

Continuity of Care: 11 COC service requests were reviewed for evidence of complete COC requirements in approval letters.

Category 3 – Access and Availability of Care

Appointment Availability: 15 contracted providers from the Provider's Directory were reviewed for appointment availability and wait times. The third next available appointment method was used to measure access to care. The Provider's Directory was reviewed for accuracy and completeness.

Emergency Service and Family Planning Claims: 21 emergency service claims and 15 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 45 grievances, including ten quality of care, 16 quality of service, 13 exempt, and six expedited were reviewed for timely resolution, appropriate response to complainant, and submission to the appropriate level for review.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse Reporting: Ten cases were reviewed for proper reporting of suspected fraud, waste, or abuse 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 Care
AUDIT PERIOD: October 1, 2018 through September 30, 2019 **DATE OF AUDIT: October 7, 2019 through October 11, 2019**

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.5	CONTINUITY OF CARE

2.5.1 Continuity of Care Approval Letter

California Health and Safety Code (HSC) requires the Plan to provide completion of covered services for serious and chronic conditions. The Plan is required to provide completion of the covered service for a period of time necessary to complete the course of treatment and to arrange for a safe transfer to another provider. Completion of services shall not exceed 12 months from the effective date for a newly covered enrollee. *(HSC CA HLTH & S section 1373.96(c)(2))*

According to *All Plan Letter 18-008*, the Plan is required to notify members within seven calendar days of the request approval for COC; the duration of the COC arrangement; the transition process that will occur at the end of the COC period; and the member's right to choose a different provider from the Plan's network. The Plan is also required to notify members about the transition process 30 calendar days prior to the end of the COC period.

Finding: The Plan did not notify members of the complete COC transition process. The Plan did not ensure COC approval letters contained all the required information including transition of care at the end of the COC period and the member's right to choose a different provider from the Plan's network.

Plan policy, *MC_12A5 Care Management Requirements-Continuity of Care,* has COC policies and procedures in place allowing members with pre-existing provider relationships and transitioning from Medi-Cal Fee-For-Service into the Managed Care Plan, the option to continue treatment for up to 12 months. The Plan notifies members of COC decisions via approval letters. The Plan's letter informs members of the approved service, approved provider, and expiration of the COC period. However, the verification study revealed approval letters sent to members did not contain information regarding transition of care at the end of the COC period nor the member's right to choose a different provider from the Plan's network.

The Plan did not have an effective monitoring process to ensure all COC requirements were met in the approval letters. During the onsite interview, the Plan confirmed COC approval letters did not contain all the required transition of care information.

Lack of complete information regarding the COC transition process may cause delays in member care leading to poor health outcomes.

❖ COMPLIANCE AUDIT FINDINGS ❖
PLAN: Inland Empire Health Care
AUDIT PERIOD: October 1, 2018 through September 30, 2019 **DATE OF AUDIT: October 7, 2019 through October 11, 2019**

Recommendation: Revise procedures and implement a monitoring process to ensure members' approval letters contain all the required COC information including transition of care at the end of the COC period, and member's right to choose different providers from the Plan's network.

❖ COMPLIANCE AUDIT FINDINGS ❖
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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

3.1.1 Telephone Waiting Times

The Plan is required to establish acceptable accessibility standards in accordance with *California Code of Regulation (CCR), Title 28, section 1300.67.2.1*. The Plan shall communicate, enforce, and monitor providers' compliance with accessibility requirements. (*Contract, Exhibit A, Attachment 9 (3)*)

The Plan is required to develop, implement, and maintain procedures to monitor waiting times for providers to answer and return telephone calls.
(Contract, Exhibit A, Attachment 9 (3)(C))

The Plan is required to implement prompt investigation and corrective action when compliance monitoring discloses the Plan's provider network is not sufficient to ensure timely access, which includes but is not limited to taking all necessary and appropriate action to identify causes underlying identified timely access deficiencies and bring its network into compliance. (*CCR, Title 28, section 1300.67.2.2 (d)(3)*)

Finding: The Plan did not have procedures to monitor waiting times for providers to answer and return members' telephone calls.

Plan policy, *MC_09A Access Standards,* does not include procedures to monitor waiting times for providers to answer and return members' telephone calls. Review of the Plan's grievance logs revealed instances of members unable to reach providers for medical appointments due to unanswered and unreturned phone calls from providers.

According to the onsite interview, the Plan identified these access deficiencies but did not take corrective action to address providers' compliance to monitor waiting times to answer and return members' telephone calls.

Lack of procedures to monitor waiting times for providers to answer and return telephone calls may cause delays in medically necessary treatments.

Recommendation: Develop and implement procedures to monitor waiting times for providers to answer and return members' telephone calls.

❖ COMPLIANCE AUDIT FINDINGS ❖
PLAN: Inland Empire Health Care
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CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Member Grievance Resolution Status Notification

The Plan shall implement and maintain procedures to monitor and ensure timely resolution and feedback relating to members' grievances in accordance with *CCR, Title 22, section 53858* and *Title 28, section 1300.68*. *(Contract, Exhibit A, Attachment 14 (2)(A))*

The Plan shall adhere to requirements and time frames in processing member grievances. In the event resolution is not reached within 30 calendar days, the member shall be notified in writing by the Plan of the status of the grievance and provided with an estimated completion date of resolution. *(CCR, Title 22, section 53858 (g)(2))*

Finding: When grievance resolution were not reached within 30 calendar days, the Plan did not have procedures to timely notify members of the grievance status and estimated completion date.

Plan policy, *MC_016A-Member Grievance Resolution Process,* does not include procedures to promptly notify members of the grievance status and estimated resolution date when a grievance is not resolved within 30 days. The verification study confirmed 15 grievances were not resolved within 30 days and members were not notified in writing the grievance status and an estimated completion date of resolution.

During the onsite interview, the Plan confirmed they did not have procedures to notify members with the status of their grievance and an estimated completion date of resolution.

Members that are not informed of their grievance status may make poor decisions leading to poor health outcomes.

Recommendation: Develop and implement procedures to ensure members are notified in writing of the grievance status and the estimated completion date when grievance resolution is not reached within 30 days.

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AUDITS AND INVESTIGATIONS
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REPORT ON THE MEDICAL AUDIT OF

INLAND EMPIRE HEALTH PLAN

Contract Number:	03-75797 State Supported Services
Audit Period:	October 1, 2018 Through September 30, 2019
Report Issued:	January 8, 2020

TABLE OF CONTENTS

I. INTRODUCTION

This report represents the recent 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 period was October 1, 2018 through September 30, 2019. The onsite audit was conducted from October 7, 2019 through October 11, 2019.

An Exit Conference with the Plan was held on December 11, 2019.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Inland Empire Health Plan

AUDIT PERIOD: October 1, 2018 through September 30, 2019
DATE OF AUDIT: October 7, 2019 through October 11, 2019

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. Such changes shall not require an amendment to this Contract. *(Contract, Exhibit A, (1))*

Plan Policy *OPS/CLM P-13: State Supported Services Abortion* 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.

The onsite interview confirmed the Plan provided State Supported Services to its members and all required procedure codes were verified within their billing system. There were no deficiencies noted during this audit period.