MEDICAL REVIEW – RANCHO CUCAMONGA
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

INLAND EMPIRE HEALTH PLAN
CAL MEDICONNECT AUDIT REPORT

2021

Contract Number:	H5355
Audit Period:	October 1, 2019 Through July 31, 2021
Report Issued:	February 18, 2022

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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 began operation on September 1, 1996. The Plan is headquartered in Rancho Cucamonga, California. The Plan is a public entity, formed as a Joint Powers Agency, and a not-for-profit health plan.

In collaboration with the Centers for Medicare and Medicaid Services, the State of California Department of Health Care Services (DHCS) operates a program to integrate care for beneficiaries who are eligible for both Medicare and Medi-Cal, also called Cal MediConnect (CMC). The program is an alternative effort under the Coordinated Care Initiative. The goal of the CMC program is to provide enrolled beneficiaries with a more coordinated, person-centered care experience, along with access to new services.

The CMC Contract is a three-way Contract between Children's Medical Services (CMS), DHCS, and Medicare-Medicaid health plans to coordinate the delivery of care for covered Medicare and Medicaid services for CMC enrollees. The covered services include medical, behavioral health, long-term institutional, and home-and-community based services.

Individuals that enroll (Enrollees) in the CMC Plan receive all Medicare and Medi-Cal benefits, including medical care, behavioral health services, and long-term services and support. They also receive Home and Community-Based Services, such as In-Home Support Services, Community Based Adult Services, and Multipurpose Senior Services Program, in addition to non-emergency transportation services and nursing facility care.

The Plan's CMC provider network consists of approximately seven Independent Physician Associations (IPA) and 32 hospitals. The Plan also directly Contracts with 1,003 Primary Care Physicians and 2,019 specialists.

As of July 31, 2021, Inland Empire Health Plan's enrollment for its Medi-Cal line of business was 1,383,946 and 31,119 for CMC, with a total enrollment of 1,415,065.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit of the Plan's CMC Contract for the period October 1, 2019 through July 31, 2021. The review was conducted from September 27, 2021 through October 8, 2021. The audit consisted of document review, verification studies, and interviews with Plan administrators, key personnel and delegated entity.

An Exit Conference was held on January 28, 2022. 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 results of the evaluation are reflected in this report.

The audit evaluated five categories of performance: Utilization Management (UM), Continuity of Care, Access and Availability of Care, Member's Rights, and Quality Management (QM).

The prior DHCS CMC medical audit report issued on January 17, 2019 (audit period October 1, 2017 through September 30, 2018) identified deficiencies incorporated in the Corrective Action Plan (CAP) dated July 11, 2019. This year's audit included review of documents to determine implementation and the effectiveness of the Plan's CAP.

The summary of findings by category is as follows:

Category 1 – Utilization Management

The Plan is required to thoroughly document the periodic review and evaluation of their appeal system. The Plan did not document the periodic review conducted by its governing body, public policy body, and officer.

The Plan is required to identify the name of the decision maker within the appeal written notification letters. The Plan did not ensure the name of the decision maker was identified within the appeal written notification letters.

Category 2 – Case Management and Coordination of Care

During the prior audit, the Plan did not document timely completion of Health Risk Assessments (HRA) for enrollees. In response to the CAP, the Plan established a new in-house HRA outreach process, provided training, and updated policies and procedures to ensure timely completion. Review of the Plan's CAP response yielded no findings.

Category 3 – Access and Availability of Care

Plans and transportation brokers must use a DHCS approved Physician Certification Statement (PCS) form to determine the appropriate level of service for Medi-Cal beneficiaries. The Plan did not ensure the required PCS forms were utilized for transportation services provided, nor did the Plan ensure PCS forms contained all required components.

Plan transportation providers are required to be enrolled in the Medi-Cal program. The Plan did not have a process in place to ensure its subcontracted transportation providers were enrolled in the Medi-Cal program.

Category 4 – Member (Enrollee) Rights

During the prior audit, the Plan did not refer all clinical grievances to a Medical Director for resolution. In response to the CAP, the Plan implemented policies and procedures requiring that a Medical Director adjudicate all clinical grievances. Review of the Plan's CAP response yielded no findings.

During the prior audit, the Plan did not classify all enrollee expressions of dissatisfaction as grievances during inquiry calls. In response to the CAP, the Plan conducted grievance training for all member service representative staff in order for the Plan to appropriately identify enrollee expressions of dissatisfaction. Review of the Plan's CAP response yielded no findings.

The Plan is required to adopt and maintain procedures to protect its enrollees from incurring payment liabilities for covered services provided. The Plan did not maintain adequate balance billing policies and procedures to protect enrollees from liability payments.

Category 5 – Quality Management

The Plan is required to maintain a system that ensures accountability for delegated Quality Improvement (QI) activities including the continuous monitoring, evaluation, and approval of delegated functions. The Plan did not maintain adequate oversight of its UM delegates. The Plan did not require delegates to report UM findings quarterly and did not monitor delegate reporting of underutilization.

III. SCOPE / AUDIT PROCEDURES

SCOPE

The DHCS, Medical Review Branch conducted this audit of the Plan to ascertain that medical services provided to CMC enrollees complied with federal and state laws, Medi-Cal regulations and guidelines, and the Three-Way Contract.

PROCEDURE

The review was conducted from September 27, 2021 through October 8, 2021 for the audit period October 1, 2019 through July 31, 2021. 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 administrators, key personnel and delegated entity.

The following verification studies were conducted:

Category 1 – Utilization Management

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

Appeal Procedures: 32 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Continuity of Care: Five enrollee files were reviewed for processing and compliance with the required timeframes.

Category 3 – Access and Availability of Care

Non-Emergency Medical Transportation and Non-Medical Transportation (NEMT/NMT): Six NEMT and four NMT records were reviewed to confirm compliance with transportation requirements and appropriateness of service provided.

Delegated NEMT/NMT Transportation: One NEMT and four NMT records were reviewed to confirm compliance with transportation requirements and appropriateness of service provided.

Category 4 – Member (Enrollee) Rights

Grievance Procedures: Ten quality of care and 30 quality of service grievance cases were reviewed for timely resolution, appropriate response to complainant, and submission to the appropriate level for review.

Category 5 – Quality Management

QI System: Six potential quality incident files were reviewed for evaluation and effective action taken to address needed improvement.

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

❖ COMPLIANCE AUDIT FINDINGS – Cal MediConnect ❖
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CATEGORY 1 - UTILIZATION MANAGEMENT

1.3	PRIOR AUTHORIZATION REQUIREMENTS

1.3.1 Appeals System Oversight

The Plan must have a system in place for reporting to the DHCS the number and types of appeals, and resolutions related to CMC, in compliance with 42 C.F.R. § 438.416 and, in the format specified by DHCS in accordance with applicable Dual Plan Letters (DPLs). *(Three-way Contract, 2.14.2)*

The Plan is required to comply with all applicable federal and state regulations and laws, as well as DHCS DPLs and applicable DHCS All Plan Letters (APL). *(Three-way Contract, 5.7.1.5)*

The written record of appeals shall be reviewed periodically by the governing body of the Plan, the public policy body created pursuant to section 1300.69, and by an officer of the Plan or their designee. The review shall be thoroughly documented. (*CCR, Title 28, section 1300.68 (b)(5)*)

The written record of appeals shall be reviewed periodically by the governing body of the Managed Care Plan (MCP), the public policy body and by an officer of the MCP or designee. The review shall be thoroughly documented. *(APL 17-006)*

Finding: The Plan did not document the periodic review and evaluation of their appeals written log. The Plan did not have documentation of the review conducted by the governing body, public policy body and officer, or designee.

Review of the Plan's Governing Body and Public Policy Participation Committee meeting minutes did not contain review of the written log of appeals during the audit period. The Plan did not adequately document their review that would demonstrate the quality interventions implemented.

Without adequate documentation of the Plan's oversight and review of appeal logs, the governing board will lack the ability to understand enrollees' actual issues which can lead to missed QI opportunities.

Recommendation: Develop and implement procedures to ensure thorough documentation of periodic appeals review by the governing body, public policy body, and officer or designee.

1.3.2 Decision Maker and Written Notification Letters

In compliance with 42 C.F.R. § 438.406(b), the Plan is required to ensure that decision makers on appeals were not involved in previous levels of review and shall include the name of the Plan representative that resolved the grievance. *(Three-way Contract, 2.14.2.1.3.6 and 2.14.2.1.3.7.6)*

The Plan is required to comply with all applicable federal and state regulations and laws, as well as DHCS DPLs and applicable DHCS APLs. *(Three-way Contract, 5.7.1.5)*

MCPs shall comply with all other existing state laws and regulations in determining whether to approve, modify, or deny requests by providers prospectively, concurrently, or retrospectively. For decisions based in whole or in part on medical necessity, the written Notice of Action letter shall contain the name and direct telephone number or extension of the decision maker. *(APL 17-006)*

Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification.
(CA Health & Safety Code § 1367.01 (h) 4)

The Plan's policy *MC_16A (revision date: 1/01/2021) Grievance and Appeals Resolution Process for Members (Standard and Expedited)* states in part that the Plan provides enrollees with clear and concise written responses to grievances and appeals which includes the reason for response, and explanations regarding denials and modifications. In addition, the policies also state that the Plan provides enrollees with copies of the case, including medical records and information used to make a decision.

Finding: The Plan did not identify the name of the decision maker within the written appeal notification letter.

The Plan's written notification letters did not meet the requirement to identify the name of the decision maker for the proposed resolution of appeals. The verification study revealed the following:

- 32 appeal resolution letters did not have the name of the health care professional responsible for the denial, delay or modification.

- Four downgraded expedited appeal request notification letters did not have the name of the health care professional responsible for the decision.

During the interview, the Plan stated the decision maker's name was not included within the appeal written notification letters due to their interpretation of the requirement, and

as a result the resolution letters identified the decision maker's specialty of practice but did not identify the individual's name.

Having the name of the health care professional responsible for appeal decisions allows enrollees to quickly locate the individual and provides the opportunity to facilitate the exchange of additional information to possibly reverse an adverse decision.

Without the name of the decision maker contained within written notification letters, the enrollee may have further delays in receiving medically necessary services.

Recommendation: Revise policy and implement procedures to include the name of the health care professional responsible for making the appeal decision within written notification letters.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.8	NON-EMERGENCY MEDICAL TRANSPORTATION AND NON-MEDICAL TRANSPORTATION

3.8.1 Physician Certification Statement form

The Plan is required to comply with all applicable federal and state regulations and laws, as well as DHCS DPLs and applicable DHCS APLs.
(Three-way Contract, 5.7.1.5)

According to the APL 17-010, NEMT services are a covered Medi-Cal benefit when members need to obtain medically necessary covered services and when prescribed in writing by a physician, dentist, podiatrist, mental health or substance use disorder provider. Plans and transportation brokers must use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. In order to ensure consistency amongst all Plans, all NEMT PCS forms must include, at a minimum, the following: function limitations justification, dates of service needed, modes of transportation needed, and certification statement.

The Plan's policy, *MA_09G Non-Emergency Medical and NMT Service (revision date: 1/01/2021)* mirrors APL 17-010 stating in part, NEMT services are a covered Medi-Cal benefit when prescribed in writing by an approved treating provider. The policy also states that treating providers must complete and submit the PCS form to the Plan prior to the provision of transportation services.

Finding: The Plan did not ensure the required PCS forms were utilized for transportation services provided, nor did the Plan ensure PCS forms contained all required components.

The verification study revealed five transportation files did not contain the required PCS forms. The verification study also revealed that the provider's electronic PCS form was not DHCS approved and did not include the required dates of service.

According to APL 17-010, plans and transportation brokers must use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members.

According to the interview, non-acquisition of the PCS form did not preclude enrollees from receiving transportation services. As a result, enrollees were transported without the necessary DHCS approved PCS form. The Plan also explained that an electronic PCS form is maintained within the portal for ease of provider use. The Plan however,

did not have procedures in place to ensure its electronic PCS form was DHCS approved and contained all required components.

Without obtaining a DHCS approved form that contains all required components, the Plan cannot ensure enrollees receive the necessary and appropriate level of transportation services which can potentially result in patient harm.

Recommendation: Revise and implement policies and procedures to ensure DHCS approved PCS forms contain all required components and are obtained prior to providing transportation services.

3.8.2 Enrollment of subcontracted transportation providers

The Plan is required to oversee and remain accountable for any functions and responsibilities delegated to its subcontractor and shall meet the subcontracting requirements as per the Contract. *(Three-way Contract, 2.9.10.2)*

The Plan is required to ensure all network providers are enrolled in the Medi-Cal program. MCP will remain contractually responsible for the completeness and accuracy of the screening and enrollment activities. To ensure that the subcontractor meets both the MCP's and DHCS' standards, the delegating MCP must evaluate the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities. The MCP must continuously monitor, evaluate, and approve the subcontracted functions. *(APL 19-004)*

Plan Policy *Pro_Con 08 Processing Agreement for perspective direct Providers (revision date: 1/01/2021)*, states in part that network providers are required to enroll in the Medi-Cal program.

Finding: The Plan did not have a process in place to ensure its subcontracted transportation providers were enrolled in the Medi-Cal program.

The Plan utilizes a subcontracted vendor to assist in providing ground transportation services to enrollees. According to the Plan's agreement, the transportation subcontractor is required to comply with all applicable state, federal and contractual requirements.

Although the Plan stated during the interview that weekly discussions were conducted with their transportation vendor to address operation and grievance issues, this weekly forum did not address Medi-Cal enrollment for transportation providers. The Plan did not have a process in place to ensure its subcontracted transportation vendor complied with Medi-Cal enrollment requirements.

Without adequate oversight, the Plan cannot ensure its subcontracted transportation vendor is in compliance with Medi-Cal enrollment requirements which can potentially result in enrollees receiving unsafe transportation services. In addition, lack of subcontractor oversight can result in missed QI opportunities.

Recommendation: Revise policy and implement a process to ensure NEMT and NMT subcontractors' compliance with Medi-Cal enrollment requirements.

CATEGORY 4 – ENROLLEE RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Enrollee Balance Billing Protection

The three-way Contract states in part that the Plan must protect enrollees from liability payments in accordance with 42 C.F.R. § 438.106 and not hold an enrollee liable for covered services provided. The contractor is required to ensure enrollees are not charged for services provided under this Contract. *(Three-Way Contract 5.1.12)*

According to the Contract, the Plan shall ensure that all Contracts or arrangements with first tier, downstream, and related entities contain enrollee protections that include prohibiting providers from holding an enrollee liable for payment of any fees that are the obligation of the contractor. *(Three-Way Contract, Appendix C)*

According to DPL 16-002, balance billing is the practice of billing beneficiaries for any charges related to covered services that are not reimbursed by Medicare or Medi-Cal. Balance billing is prohibited by state and federal law.

Title 42, Code of Federal Regulations (CFR) section 422.504, states in part that the Plan must provide that its Medicaid enrollees are not held liable for covered services furnished under the Contract. The Plan must adopt and maintain arrangements to protect its enrollees from incurring payment liabilities. To meet this requirement, the Medicare Advantage Organization must ensure that all contractual or other written arrangements prohibit the organization's providers from holding any enrollee liable for payment of any such fees. *(42 C.F.R. § 422.504 (g)(1))*

Plan policy, *MA_20B Billing of IEHP members (revision date: 01/01/2021)* states in part that it is illegal to bill a Health Maintenance Organization enrollee for whom services were provided, except for non-benefit items or non-covered services. The policy also states in part, the Plan will open a case for further research and action once notified that an enrollee has received a balance bill. However, the Plan's policy did not adequately address provider oversight procedures to protect enrollees from incurring further payment liabilities for covered services.

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Finding: The Plan did not maintain adequate balance billing policies and procedures. The Plan did not have a process to protect enrollees from liability payments.

Enrollee instructions are contained within the *Evidence of Coverage* that explain the appropriate steps to take when a balance bill is received. The Plan, however, did not take effective action when addressing enrollee balance bill complaints.

The verification study noted 12 exempt grievance cases in which enrollees filed complaints due to receiving bills ranging from $20.00 to $4,000.00 from the Plan's providers. Although enrollees were advised that the balance bills were sent in error, these grievances were resolved without adequate research or further investigation. As a result, the Plan did not track or trend this data and did not adequately monitor the providers with improper billing practices.

Without effective enrollee protection, balance billing may cause undue financial stress and hardship to a sensitive population with limited income and resources. In addition, inadequate oversight of provider improper billing practices may result in missed QI opportunities.

Recommendation: Develop and implement effective oversight policies and procedures to protect enrollees from liability payments.

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CATEGORY 5 – QUALITY MANAGEMENT

5.1	QUALITY IMPROVEMENT SYSTEM

5.1.1 Quality Improvements

According to the Contract, the Plan is accountable for all delegated QI functions and responsibilities (e.g.UM). The Plan is required to maintain a system to ensure accountability for delegated QI activities that at a minimum includes the continuous monitoring, evaluation and approval of the delegated functions. *(Three-way Contract, 2.16.3.3.1, 2.16.3.3.2, and 2.16.3.3.2.3)*

The Plan is required to establish a mechanism to detect both underutilization and overutilization of services and assess the quality and appropriateness of care furnished to enrollees with special health care needs. *(Three-way Contract, 2.16.3.2.and* 2.16.3.2.1*)*

Plan policy *PRO_DEL 06 Delegation Oversight Committee (revision date: 01/01/2021)* states in part the Plan's Delegation Oversight Committee audits and monitors on a monthly basis, the operational activities of contracted IPAs and other delegate activities such as, UM, grievances, and appeals.

Plan policy *MC_25 D3 QM - CAP Requirements (revision date: 1/01/2020)* states in part that QM monitoring activities include monthly, quarterly, semi-annual, and annual report submission.

Finding: 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.

The Plan did not require their delegates to report UM findings quarterly as required by its policy and the Contract. The Plan stated that its delegates were only required to submit UM program reports semi-annually and annually, in which the Plan provides review and recommendations for improvement.

Additionally, the Plan did not adequately monitor delegate reporting of underutilization. Review of nine IPA Industry Collaborative Effort reports submitted to the Plan for review, did not have underutilization data.

Receipt and review of delegated UM reports on a semi-annual basis instead of a quarterly basis may delay initiation of effective action necessary to address any needed improvements in the quality of care delivered by Plan delegates. Without adequately monitoring delegate reporting of underutilization, the plan cannot ensure that medically necessary services are appropriately utilized which could negatively impact enrollees' overall health.

Recommendation: Revise and implement policies and procedures to ensure adequate oversight of UM delegates, early identification of issues, and timely initiation of interventions through QI activities.