State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
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December 9, 2022

Erika Oduro, Regulatory Affairs Manager
Inland Empire Health Plan
10801 6th St., Ste. 120
P.O. Box 1800
Rancho Cucamonga, CA 91729

RE: Department of Health Care Services Cal MediConnect Audit

Dear Ms. Oduro:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Cal MediConnect Audit of Inland Empire Health Plan, a Medicare-Medicaid Plan (MMP), from September 27, 2021 through October 8, 2021. The audit covered the period of October 1, 2019 through July 31, 2021.

All items have been evaluated and DHCS accepts the MCP's submitted Corrective Action Plan (CAP). The CAP is hereby closed. The enclosed documents will serve as DHCS' final response to the MCP's CAP. Closure of this CAP does not halt any other processes in place between DHCS and the MCP regarding the deficiencies in the audit report or elsewhere, nor does it preclude the DHCS from taking additional actions it deems necessary regarding these deficiencies.

Please be advised that in accordance with Health & Safety Code Section 1380(h) and the Public Records Act, the final report and the enclosed documents will be made available on the DHCS website and to the public upon request.

If you have any questions, please reach out to CAP Compliance personnel.

Sincerely,

[Signature on file]

Oksana Meyer, MPA
Chief, CAP Compliance & FSR Oversight Section
Managed Care Quality & Monitoring Division
Department of Health Care Services

Enclosures: Attachment A (CAP Response Form)

cc: Lyubov Poonka, Chief
CAP Compliance Unit
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Department of Health Care Services

Diana O'Neal, Lead Analyst
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Rebeca Cabiedes, Contract Manager
Medi-Cal Managed Care Division
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ATTACHMENT A
Corrective Action Plan Response Form

Plan: Inland Empire Health Plan

Review Period: 10/01/2019 – 07/31/2021

Audit Type: Cal MediConnect

On-site Review: 09/27/2021 – 10/08/2021

MCPs are required to provide a CAP and respond to all documented deficiencies within 30 calendar days, unless an alternative timeframe is indicated in the CAP Request letter. MCPs are required to submit the CAP in word format that will reduce turnaround time for DHCS to complete its review. According to ADA requirement, the document should be at least 12 pt.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. The MCP shall directly address each deficiency component by completing the following columns provided for MCP response: 2. Action Taken, 3. Implementation Documentation, and 4. Completion/Expected Completion Date. The MCP will be required to include project timeline with milestones in a separate document for each finding. Supporting documentation should accompany each Action Taken. For policies and other documentation that have been revised, please highlight the new relevant text. For deficiencies that require short-term corrective action, implementation should be completed within 30 calendar days. For deficiencies that may be reasonably determined to require long-term corrective action for a period longer than 30 days to completely remedy or operationalize, the MCP is to indicate that it has initiated remedial action and is on the way towards achieving an acceptable level of compliance. In those instances, the MCP will be required in addition to the above steps, to include the date when full compliance will be achieved. **Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval, as applicable in accordance with existing requirements.**

DHCS will maintain close communication with the MCP throughout the CAP process and provide technical assistance to ensure the MCP provides sufficient documentation to correct deficiencies. Depending on the volume and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates, as applicable.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
1. Utilization Management				
1.3.1 Appeals System Oversight The Plan did not document the periodic review and evaluation of their appeals system. The Plan did not have documentation of the review done by the governing body, public policy body and officer, or designee.	1. **Review of Written Log** – The Plan will present to the Governing Board and the Public Policy Participation Committee (PPPC) its Grievance & Appeals (G&A) written log, along with summary and trends identified. Appropriate time will be allotted to allow for meaningful review and discussion of information, including but not limited to the identification of issues, and quality improvement opportunities. The Plan will leverage the meeting minutes and/or working papers to document the review and evaluation of the G&A written log. 2. **Oversight** – This activity will be added to the QM/QI Workplan to ensure that the written log is presented to the Governing Board and	The Plan will provide the following documentation: • Revised policies and procedures that describe review of the written log by the Governing Board & PPPC • Updated QM/QI Workplan • Governing Board & PPPC Meeting Minutes and/or Working Papers • Sample report and written log presented to the Governing Board & PPPC	**Short-Term:** N/A **Long-Term:** • **06/13/22** – On or before this date, review G&A written log for CMC with Governing Board • **06/15/22** – On or before this date, review G&A written log for Medi-Cal and CMC with PPPC	The following additional documentation supports the MCP's efforts to correct this finding: **Implementation/Oversight & Monitoring** Governing Board meeting report/meeting minutes (4/11/22) that demonstrates the review and evaluation of the written appeals log; including the following: Grievance and Appeals Annual Study • Review case volume and identify trends and assess areas of opportunity to improve member satisfaction • Grievance and appeals are grouped by category: Access, attitude/service, benefits, billing, compliance, enrollment/disenrollment, quality of care, quality of provider site. Outlines next steps: • Identify transportation trends/address issues • Establish escalation protocol for transportation related issues • Transportation vendor on CAP • Establish escalation process for PCPs with identified trends, address quality of care issues Public Policy Participation Committee Report • Grievance and Appeals Process report used to enhance member experience and identify improvement opportunities. Report includes the following:

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	PPPC timely and consistently.			• Case volume 2021 • Top five G&A categories Grievance improvements • Provider change process within the member portal • Online grievance forms • Transportation broker was placed on a CAP – late drivers/missed appointments, specifically related to dialysis patients. • Updated call center hold messages Appeals Improvements • Improve consistence in nurse recommendations and medical director reviews • Ensure appropriate application of review of grievance and appeal logs • Review overturned appeals, identify trends and promote discussion for remediation Public Policy Participation Committee (PPPC) meeting minutes • Plan provided documented evidence of the review of grievance and appeal logs • Discussion included audit findings, decline to file, exempt, and standard grievances and appeals. • Top categories and potential root cause/impact – pandemic, staffing, included member participation/discussion regarding decline to file situations. 2022-2024 Quality Management/Quality Improvement Work Plan

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				• Provide updates from the Grievance and Appeals Review Committee. The purpose of the committee is to provide direction necessary to monitor and evaluate Grievance and Appeals related data and to provide guidance in identifying trends and develop action plans to resolve Grievance and Appeal trends and focus improvement activities throughout IEHP. Grievance and Appeals Study - The purpose of this study is to assess Member experience with Inland Empire Health Plan (IEHP) services by evaluating grievances and appeals trends. The Grievance and Appeal (G&A) Study is conducted annually and reviews case volume and rates to identify trends and assess areas of opportunity to improve overall Member satisfaction. **The Corrective Action Plan for Finding 1.3.1 is accepted.**
1.3.2 Decision-Maker & Written Notification Letters The Plan did not identify the name of the decision maker within the written notification appeal letter.	1. The Plan reviewed the regulations cited in the DHCS Final Audit Report and found that these requirements do not apply to appeal notifications for CMC/Medicare line of business.	N/A	N/A	The following additional documentation supports the MCP's efforts to correct this finding: **Implementation** - Examples of Notice of Appeal Resolution Letters were provided that show the decision maker's name is included. - DTR-094-APP-Medical Appeals Process demonstrates the MMP has configured its system to pull from the appeal decision maker field to ensure its inclusion in appeal resolution letters. **Monitoring**

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				- G&A QA Plan demonstrates the MMP monitors appeal resolution letters and expedited/downgrade appeal to ensure the decision maker's name is included. **The Corrective Action Plan for Finding 1.3.2 is accepted.**
3. Access and Availability of Care				
3.8.1 Physician Certification Statement (PCS) Form 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.	1. **PCS Form Elements** – The Plan will revise the online PCS form on the secure IEHP Provider portal to match the DHCS-approved PCS form by including the Date of Service, which had been inadvertently omitted. 2. **Obtaining PCS Form** – The Plan will begin conducting telephonic outreach to the Provider to ensure a completed PCS form is on file for NEMT requests. 3. **Training & Communication** • Providers will be reminded that a completed PCS form	The Plan will provide the following documentation: • Screenshot of updated online PCS form • Process Documentation – NEMT Requests • Onboarding Training - Transportation • Revised Policies and Procedures • Training and communication materials	**Short-Term**: • **05/01/22** – On or before this date, send out communication to Providers reminding them of the requirement to submit PCS forms. • **05/16/22** – On or before this date, deploy the revised online PCS form with all required elements. **Long-Term:**	The following additional documentation supports the MCP's efforts to correct this finding: **Policies & Procedures** The Plan updated P&Ps to address the gap that contributed to the deficiency: • Procedure "Physician Certification Form Quality Assurance Guide" demonstrates the Plan has a process to ensure Physician Certification Statement (PCS) Forms are captured for members requiring NEMT, being reviewed monthly by the 10th of each month. • P&P "MC_09C NEMT & NMT Services" demonstrates the following: ○ The policy has been amended to include that the Plan utilizes a PCS form that has been approved by DHCS that includes all required components to arrange for NEMT services. ○ The PCS form must be completed before NEMT can be provided. ○ The Plan ensures that a copy of the PCS form is on file for all members & that all fields will be filled out by the provider. **Implementation/Oversight & Monitoring**

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	must be on file to authorize NEMT requests. Communication will be completed through blastfax, joint operations meetings with IPAs, and targeted outreach. • The Plan's Transportation Team will be trained on the telephonic outreach process. Training will also be integrated into the onboarding process for new hires. 4. **Oversight** – The Plan will retrospectively review a random sample of NEMT requests to ensure that a completed PCS form was received, and additional outreach was conducted.		• **06/01/22 –** On or before this date, begin conducting outreach to Providers to obtain missing PCS form prior to authorizing services. • **07/01/22 –** On or before this date, implement retrospective QA review of PCS requirement and outreach	The Plan identified, developed and deployed an internal auditing process to continuously self-monitor to detect and prevent future non-compliance: • Procedure "Physician Certification Form Quality Assurance Guide" demonstrates that the Plan randomly samples 5% of daily coordination from the monthly trip log & reviews for; o Date trip received; o Date trip coordination was completed; o Was PCS form collected date of coordination; o Provider outreach completed; & o If PCS was received after outreach. • P&P "MC_09C NEMT & NMT Services" demonstrates the Plan will be tracking that the transportation broker & providers are complying with all requirements set forth in APL 22-008, ensuring monitoring activities are performed no less than quarterly, including but not limited to: o Non-modification of the level of transportation service outlined in the PCS form; o Providing door-to-door assistance for NEMT services; o NEMT & NMT providers arriving within 15 minutes of scheduled appointment time; & o No show rates for NEMT & NMT providers. • IEHP PCS Form "NEMT PCS Form" was amended to include the "transportation start date" & "transportation end date" & includes that all fields must be completed as part of IEHP's requirements. **The Corrective Action Plan for Finding 3.8.1 is accepted.**

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3.8.2 Enrollment of Subcontracted Transportation Forms The Plan did not have a process in place to ensure its subcontracted transportation providers were enrolled in the Medi-Cal program.	1. **Medi-Cal Enrollment Verification –** The Plan will verify the Medi-Cal enrollment of subcontracted providers on a monthly basis. Findings from this process will be shared with the Transportation vendor on at least a monthly basis and discussed at the quarterly Joint Operations Meetings. 2. **Retrospective Claims Review** – The Plan will retrospectively review transportation claims on a monthly basis to determine whether Transportation vendors utilized subcontracted providers who are not enrolled in the Medi-Cal program. Persistent non-compliance will result in corrective action, which may lead to further disciplinary action including but not	The Plan will provide the following documentation: • JOM Meeting Minutes • Process Documentation – Retrospective Claims Review • Training & communication materials	**Short-Term**: • N/A **Long-Term:** • **06/01/22 –** On or before this date, inform Transportation vendors of Medi-Cal enrollment requirement and oversight plan. • **07/01/22 –** On or before this date, implement retrospective claims review process	The following additional documentation supports the MCP's efforts to correct this finding: **Policies & Procedures** • P&P "MC_09C NEMT & NMT Services" demonstrates the Plan will be tracking that the transportation broker & providers are complying with all requirements set forth in APL 22-008, ensuring monitoring activities are performed no less than quarterly, including but not limited to Enrollment Status. The P&P also demonstrates the Plan has a corrective action process in place & will impose on its transportation brokers & providers should non-compliance be identified through monitoring activities. [9. Access Standards, B., page 9] **Implementation/Oversight & Monitoring** The Plan identified, developed and deployed an internal auditing process to continuously self-monitor to detect and prevent future non-compliance: • IEHP Workflow "Transportation Retrospective Review Workflow – IEHP Direct" demonstrates the following: ○ The Plan monitors & oversees transportation providers through verification of broker/provider roster on a monthly basis, validating Medi-Cal Enrollment data comparison through CHHS ODP, & utilizing the transportation roster. The workflow demonstrates the Plan is ensuring providers are within 120-day requirement, requiring after 90 days in "pending" status, to start preparing Provider termination.

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	limited to freezing from referrals. 3. **Training & Communication** • Transportation vendors will be reminded at JOMs of Medi-Cal enrollment requirements, and how their compliance will be monitored going forward. • The appropriate Team Members will be trained on the retrospective claims review process			○ The Plan is currently working with 5 providers to bring into compliance & has submitted a Plan of Action on 11/18/2022 for continuity of services. • Provider Rosters "IEHP Direct Transportation Contracted List & AL-Subcontracted List" demonstrate the following: ○ The Plan utilizes both direct transportation providers & a transportation broker for NEMT services. ○ The Plan is currently working with 5 providers to bring into compliance & has submitted a Plan of Action on 11/18/2022 for continuity of services. ○ The Plan is monitoring provider enrollment monthly, checking status of each provider to ensure Medi-Cal enrollment requirement is being met. [Column "Enrollment Status DATE"] • P&P "MC_09C NEMT & NMT Services" demonstrates the Plan has a process in place for monitoring activities, occurring no less than quarterly, including but not limited to Enrollment Status. If non-compliance is identified through monitoring activities, this will result in intervention including but not limited to Broker/Provider education, issuance of corrective action, freezing to new authorizations, and leading up to termination of contract. [9. Access Standards, B., page 9] **The Corrective Action Plan for Finding 3.8.2 is accepted.**

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4. Member Rights				
4.1.1 Enrollee Balance Billing The Plan did not maintain adequate balance billing policies and procedures. The Plan did not have a process to protect enrollees from liability payments.	1. **Process Change** – Inquiries and grievances pertaining to balance billing will be routed to the Provider Services Follow-Up Team, who will be responsible for obtaining and reviewing information to substantiate, as well as track and trend cases of balance billing. Outreach to Providers and billing parties, if it applies, will reinforce the Plan's policy against balance billing. Findings related to grievance cases will be shared with the G&A Team for case resolution. Providers that persist to balance bill will be escalated to the Compliance Special Investigations Unit for	The Plan will provide the following: • Revised Policies & Procedures • Process Documentation – Provider Services Follow-Up & CAP Process • Communication materials	**Short Term:** N/A **Long Term:** • **06/01/22 -**On or before this date, review and update Policies and Procedures • **07/01/22** – On or before this date, implement the process change. • **08/01/22** – On or before this date, implement a QA process that ensures balance billing inquiries are routed to the appropriate team.	The following additional documentation supports the MCP's efforts to correct this finding: **Policies & Procedures** - Revised P&P, "MA – 20B: "Billing of IEHP Members" (01/01/22) which has been revised to include procedures to address provider oversight and to fully address the appropriate course of action to take when a balance billing is received by a member. **Training** - Provider Training/Outreach, "IEHP Provider Training Guide" and (05/22) which provides a section on, "Providers Charging Members." This section addresses that IEHP prohibits contracted Health Care Providers from charging and/or collecting payment from Members or other persons on behalf of the Member, for covered services. If the Provider of service continues to charge a member in violation of this policy after being notified to stop, or sends the Member's account to a collections agency, IEHP reserves the right to inform the DMHC, DHCS or other regulatory agencies of the violation. In addition, the billing of Members is in violation of IEHP policy, and IEHP takes all necessary actions, up to and including termination of the Provider's participation with IEHP to ensure that such actions stop. - Training, "Job Breakdown Sheet and Recovery Grievance Process" and Attendance Report (06/02/22) addresses the process if a grievance is received in regard to balance billing.

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	further investigation for possible fraud, waste and abuse, and appropriate action, including but not limited to corrective action planning and reporting to regulatory agencies. The Plan will review policies and procedures to ensure clarity of Plan expectations. 2. **Training & Communication** – The following teams will be trained on the process change: • Member Services • Grievance & Appeals • Provider Services Follow-Up Team • Compliance Special Investigations Unit			**Monitoring/Oversight** - Tracking/Trending, “Member Bill, Balance Bill, and Bill Type, (07/22, 08/22, and 09/22) as evidence that incidents of inappropriate billing will be tracked and trended to determine when a billing Provider has had a previous occurrence. - Tracking, “Processing Member Balance Bill” (09/28/22) which describes how to create and process events in (HSP) MediTrac for Balance Bill/Member Bill. This process tracks and trends the providers with improper billing practices. - Internal Audit, “Provider Operations, Member Balance Bill Audit Schedule” (07/22) which demonstrates that billing provider reports are conducted weekly. I**mplementation** CAP Process, “Processing Member Balance Bill” (09/28/22) which ensures the Provider Payment Resolution (PPR) team will reach out to Members to educate and assist with Member Balance Bill resolution. In addition, PPR team will then reach out to the Provider/ Biller to provide Cease and Desist Letter and will work with Provider to bill appropriate payer and or educate accordingly per DHCS guidelines. Providers will be directed to Provider Manual. - CAP Process, “FWA 0019: Provider Balance Billing Investigation Process”. The Compliance Special Investigations Unit (SIU) will monitor for new reports identifying Providers that are engaging in balance billing

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				activities received from IEHP's Provider Payments Resolution (PPR) in MediTrac. Compliance SIU will conduct a pre-investigation to determine if a full investigation is warranted. - CAP Process, "FWA 0020: Member Bill - Services Not Rendered". The Compliance Special Investigations Unit (SIU) will monitor for new reports identifying Providers who sent a bill/invoice to a member who alleges the services were not rendered. Reports can be received from IEHP Member Services via MediTrac or IEHP Grievance & Appeals via MedHOK. **The Corrective Action Plan for Finding 4.1.1 is accepted.**
5. Quality Management				
5.1.1 Quality Improvements 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.	1. **Reporting Requirements** – Delegates will be required to submit their UM Workplan evaluations quarterly, rather than semi-annually. The UM Workplan will include additional UM measures as approved by the UM Subcommittee. 2. **Delegation Oversight** – The Plan will review UM Workplan evaluations on a quarterly, rather than semi-annual basis. The	The Plan will provide the following: • Revised Policies and Procedures • Communication materials	**Short-Term:** N/A **Long-Term:** • **05/11/22** – On or before this date, the UM Subcommittee will approve utilization measures • **06/01/22** – On or before this date, Delegates will be informed of changes to	The following additional documentation supports the MCP's efforts to correct this finding: **Policy & Procedures** - Updated P&P, "MC_25E2: Delegation Oversight – Utilization Management – Reporting Requirements" (01/01/21) which states that Delegates will be required to submit their UM Workplan evaluations quarterly, rather than semi-annually (1.c - REDLINED_MC_25E2 - UM Reporting Requirements, Page 2). - Updated P&P, "MED_UM 5.e: Over and Under Utilization Tracking and Reporting" (06/01/22) which states Disease-specific over and under utilization metrics as part of the reporting statistics on a monthly and/or quarterly basis (1.c - REDLINED_MED_UM 05.e - Over&Under Utilization Trckng&Rptg, Page 2).

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	Plan will provide Delegates with feedback, findings, and areas for improvement. Delegates will be required to engage in proactive interventions through quality improvement activities. 3. **Plan Oversight** – Trends and findings identified from the quarterly review of UM Workplans will be presented to the Plan's UM Subcommittee, which reports to the Quality Management Committee, and ultimately to the Plan's Governing Board. 4. **Training & Communication** • Delegates will be informed of change in reporting requirements, benchmarks and oversight process		the reporting requirements, including utilization measures. • **09/15/22** – On or before this date, the first quarterly UM Workplan is due to the Plan	**Implementation** - Communication Letter, "Changes to UM Semi-Annual and Annual Reporting Requirements" (06/01/22) as evidence that the MCP has notified all IPAs that the MCP has increased the reporting frequency of the Health Industry Collaboration Effort (HICE) UM reporting requirements from semi-annually, (February & August) to quarterly, (February, May, August, and November) (2.a - IPA Communication - UM Quarterly HICE Report). - Meeting Minutes, "UM Subcommittee Meeting" (05/11/22) in which the MCP obtained approval of utilization measures to include in the UM Workplan (1.a - UMSC Meeting Minutes 05.11.22 -Signed, Page 17). **Monitoring and Oversight** - "UM Delegation Oversight – Quarter 2 2022: UM Health Industry Collaboration Effort (HICE) Work Plan Review" as evidence that the MCP is reviewing over and underutilization metrics submitted by the delegate and providing feedback and requests back to the delegate. The report includes the following categories: Key Findings and Analysis, Interventions/Follow-up Actions, Remeasurement. (1.c - Sample Feedback Summary). - Quarterly 2022 Work Plans, "2022 HICE UM Work Plan" submitted to the MCP from several delegates in which the MCP will review UM Workplan evaluations on a quarterly, rather than semi-annual basis. The MCP will provide delegates with feedback, findings, and areas for improvement. Delegates will be required to engage in proactive interventions through quality improvement activities. The report includes the goals, analysis,

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				interventions, and evaluation in regards to over and underutilization (MCR_Q2_2022_UM WP_IEHP). **The Corrective Action Plan for Finding 5.1.1 is accepted.**

Submitted by: [Plan's Signature on File] **Date: March 9, 2022**
Title: Erika Oduro, Regulatory Affairs Manager