

MEDICAL REVIEW – LOS ANGELES SOUTHERN SECTION I  
AUDITS AND INVESTIGATIONS  
DEPARTMENT OF HEALTH CARE SERVICES

**L.A. Care Health Plan**

Contract Number: 04-36069 A08

Audit Period: April 1, 2013  
through  
March 31, 2014

Report Issued: March 11, 2015

## TABLE OF CONTENTS

I.	INTRODUCTION.....	1
II.	EXECUTIVE SUMMARY.....	2
III.	SCOPE/AUDIT PROCEDURES.....	4
IV.	COMPLIANCE AUDIT FINDINGS	
	Category 1 – Utilization Management .....	6
	Category 2 – Case Management and Coordination of Care.....	10
	Category 3 – Access and Availability of Care.....	15
	Category 4 – Member’s Rights .....	20
	Category 5 – Quality Management.....	24
	Category 6 – Administrative and Organizational Capacity .....	27

## I. INTRODUCTION

L.A. Care Health Plan (L.A. Care or the Plan) was established in 1997 as the local initiative Medi-Cal Managed Care health plan in Los Angeles County under the Two-Plan Medi-Cal Managed Care model. L.A. Care is Knox-Keene licensed and located in Los Angeles.

L.A. Care provides managed care health services to Medi-Cal beneficiaries under the provision of Welfare and Institutions Code, Section 14087.3. The Plan is a separately constituted health authority governed by an independent county Board of Supervisors. The Plan utilizes a "Plan Partner" model, under which it contracts with four health plans through capitated agreements. The Plan Partners (PPs) are Anthem Blue Cross, Care 1<sup>st</sup> Health Plan, Kaiser Permanente, and Health Net. In addition to the Plan Partner model, the Plan began providing coverage directly to Medi-Cal members under its own line of business, Medi-Cal Care Los Angeles (MCLA) in 2006. In its direct line of business, the Plan contracts with 48 Participating Physician Groups (PPGs) who are paid a capitated amount for each enrollee.

As of May 1, 2014, L.A. Care's Medi-Cal enrollment was approximately 1,446,259 members. Enrollment by product line was as follows:

- Medi-Cal Members : 1,352,036  
(PPs and MCLA)
- Healthy Kids 844
- PASC-SEIU Plan 47,372
- Medicare Advantage (SNP) 7,753
- L.A. Covered 38,000
- Cal MediConnect 254

## II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical review audit for the review period April 1, 2013 through March 31, 2014. The on-site review was conducted from June 25, 2014 through July 9, 2014. The audit consisted of document reviews, verification studies, and interviews with Plan personnel.

An Exit Conference was held on January 22, 2015 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the findings on the draft audit report. No additional information was submitted following the Exit Conference.

The audit evaluated six categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Members' Rights, Quality Management (QI), and Administrative and Organizational Capacity.

The summary of the findings by category follows:

### **Category 1 – Utilization Management**

The Plan did not comply with contract requirements regarding timely decisions on prior authorization requests. Prior authorization requests for routine medical services were not consistently processed within five working days of receipt. Pharmacy prior authorization requests were not processed within one business day of receipt. In addition, Plan providers were not regularly notified regarding decisions made on pre-service prior authorization requests within 24 hours after a decision is made.

The Plan did not have clearly defined procedures to reflect that all specialty referrals were completely tracked and that PCPs consistently receive feedback from specialists.

The Plan did not address the issue of insufficient information on original prior authorization requests. The verification study showed a majority of overturned appeals lacked information on initial submission of the requested prior authorization services. This resulted in unnecessary delays in the delivery of medically necessary services. The verification study also revealed instances in which the same physician was involved in prior decisions related to the appeal.

### **Category 2 – Case Management and Coordination of Care**

The Plan lacked documentation of referrals and monitoring procedures related to the coordination of care between the Primary Care Physicians (PCPs) or specialists for California Children's Services (CCS), Early Intervention/Developmental Disabilities (EI/DD), Early Start Program, and Regional Centers.

The Plan did not ensure the completion of Initial Health Assessments (IHAs) for all newly enrolled members within the required timeframes. The Plan did not document the required attempts to follow-up with members who missed their scheduled IHA.

### **Category 3 – Access and Availability of Care**

The Plan did not comply with the required timeframe for members to receive appointments for routine care, routine specialty care referral, and urgent care. In addition, the Plan did not comply with the required timeframe to answer member calls.

### **Category 4 – Member's Rights**

The Plan failed to fulfill its contractual reporting of grievances to its committees and Board of Governors during the audit period. The Plan did not address all issues contained within the filed grievances and did not include all issues in the resolution letters. In some instances, the Plan did not completely evaluate grievances due to missing medical records. In several cases, the Plan did not thoroughly document medical reasoning. In addition, some quality of care cases of members with chronic disease were not reviewed for potential quality improvement; there was no documentation that these cases were considered for quality improvement through care coordination and possible placement into case management.

The Plan did not report breaches within the required 24 hours. In addition, the Plan failed to notify the DHCS Information Security Officer of HIPAA regarding initial breaches as mandated by contract.

### **Category 5 – Quality Management**

The Plan's providers failed to maintain complete and accurate medical records for all members. The Plan's providers did not ensure that Informed Consent (IC) forms were properly completed and available in the medical records. In addition, members were not provided a copy of a booklet on sterilization (published by the Department).

### **Category 6 – Administrative and Organizational Capacity**

The Plan did not follow its internal policy to ensure a new provider receives training within the required 10 working days.

The Plan did not report potential fraud and abuse cases to DHCS Program Integrity Unit within the required 10 working days timeframe.

### III. SCOPE/AUDIT PROCEDURES

#### SCOPE

This audit was conducted by the DHCS Medical Review Branch (MRB) to ascertain that services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's Two-Plan Contract. This audit focused on MCLA, the Plan's own line of business providing direct coverage to Medi-Cal members.

#### PROCEDURE

DHCS conducted an on-site audit of L.A. Care from June 25, 2014 through July 9, 2014. The audit included a review of the Plan's contract with DHCS, its policies for providing services, the 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: 20 routine medical and 28 pharmacy prior authorization requests were reviewed for timeliness of decision making, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Prior Authorization Appeal Process: 30 provider and member appeals were reviewed for appropriateness and decision making in a timely manner.

#### **Category 2 – Case Management and Coordination of Care**

California Children's Services: 14 medical records were reviewed for evidence of coordination of care between the Plan and CCS providers.

Early Intervention and Developmental Disabilities: 13 medical records were reviewed for appropriateness of services received and evidence of coordination of care between the Plan and local programs such as Early Start Program and Regional Centers.

Initial Health Assessments: 19 medical records were reviewed for completeness and timely completion.

#### **Category 3 – Access and Availability of Care**

Emergency Service Claims: 20 emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: 19 family planning claims were reviewed for appropriate and timely adjudication.

#### **Category 4 – Member’s Rights**

Grievance Procedures: 60 grievances were reviewed: 30 Quality of Care and 30 Quality of Service were reviewed for timely resolution, response to complainant, and submission to the appropriate level of review.

Confidentiality Rights: 10 cases were reviewed for proper reporting of all suspected and actual breaches to the appropriate entities within the required timeframe.

#### **Category 5 – Quality Management**

Medical Records: 46 medical records were reviewed for completeness.

Informed Consent: 28 informed consent records were reviewed for completeness of Informed Consent form PM 330.

#### **Category 6 – Administrative and Organizational Capacity**

New Provider Training: 22 new provider training records were reviewed for timely provision of Medi-Cal Managed Care program training.

Fraud and Abuse Reporting: 10 cases were reviewed for proper reporting of all suspected fraud and/or abuse to the appropriate entities within the required timeframe.

The succeeding report contains description of findings for each category.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

CATEGORY 1 - UTILIZATION MANAGEMENT

1.2

PRIOR AUTHORIZATION REVIEW REQUIREMENTS

**Prior Authorization and Review Procedures:**

Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements... (as required by Contract)  
2-Plan Contract A.5.2.A, B, D, F, H, and I.

**Exceptions to Prior Authorization:**

Prior Authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.  
2-Plan Contract A.5.2.G

**Notification of Prior Authorization Denial, Deferral, or Modification:**

Contractor shall notify Members of a decision to deny, defer, or modify requests for prior authorization, in accordance with Title 22 CCR Sections 51014.1 and 53894 by providing written notification to Members and/or their authorized representative... This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, and 53894, and Health and Safety Code Section 1367.01.  
2-Plan Contract A.13.8.A

**SUMMARY OF FINDINGS:**

The Contract requires the Plan to ensure decisions on prior authorization decisions are made in a timely manner and not unduly delayed for medical conditions requiring time sensitive services. Reasons for decisions shall be clearly documented and the Plan shall notify members or the requesting provider of any decision within the required timeframe. The Plan did not meet its contractual requirements for decision making in a timely manner of routine medical and pharmacy prior authorization requests. The Plan did not comply with its own policies and procedures outlining processes to meet these requirements.

Policy and Procedure Numbers (P&P) UM-112: *UM and Pharmacy Timeliness Standards for Decision Making and Notification* and UM-112: *Attachment A* outline the required timeliness standards for utilization review decision making and subsequent notification timeframes of the decision to both the member and provider. For routine medical requests, a decision shall be made within five working days of receipt of the request. The Plan shall inform the member or requesting provider of decisions within 24 hours. Policy and Procedure Number UM-108: *Delaying a Pre-Service Authorization Request* states that when a decision is made to delay a routine medical decision, a formal Delay Letter should be prepared and sent to the member and requesting provider.

During onsite interview, the Plan acknowledged there were timeliness issues with its prior authorization process. Personnel issues along with procedural steps in obtaining authorization contributed to delays in rendering a decision within five days on routine prior authorization requests.

The verification study revealed decisions were late (after five working days) for 13 routine medical and two pharmacy prior authorization cases. For five routine medical prior authorization cases, notifications to providers were late (more than 24 hours after decision was made). One case with a deferred decision did not have written notification to the provider and member until after the authorization was denied. Three routine medical prior authorization cases lacked clear and concise language in the Notice of Action letters.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

**RECOMMENDATIONS:**

- Adhere to P&P UM-112 regarding the required timeframes for decisions on prior authorization requests.
- Ensure the Plan notifies members or requesting provider of decisions within the 24-hour requirement.
- Ensure a formal Delay letter is prepared and sent to the member or requesting provider when a delay decision is made on routine medical prior authorization requests.
- Ensure clear and concise language is in the Action of Notice letters to members.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

1.3

### REFERRAL TRACKING SYSTEM

#### **Referral Tracking System:**

Contractor is responsible to ensure that the UM program includes: ... An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.

2-Plan Contract A.5.1.F

#### **SUMMARY OF FINDINGS:**

The Contract requires the Plan to ensure the UM program includes an established specialty referral system to track and monitor referrals requiring prior authorization. However, the Plan did not have a system to track specialist referrals to completion. The Plan did not ensure PCPs consistently received feedback from specialists. The Plan failed to track open or unused referrals and define timeframes for audits of referral logs.

The Plan delegates the responsibility for referral tracking to the PCP. When a PCP determines a member requires specialty services or examinations, the PCP must make the referral request to the PPG or the designated hospital physician. All PCPs are required to track referrals for follow-up through a tickler file/log or computerized tracking system. The initiating PCP must ensure that a member was seen by the specialist and the outcome is documented in the medical record.

Review of UM Committee minutes during the audit period determined that the minutes did not give any details of the referral tracking process. The 2013 UM Program Evaluation mentioned referrals were tracked and monitored for compliance, but no specifics of tracking reports were mentioned.

The Quality Improvement Annual Evaluation conducted in 2013 reported on a survey regarding communication between PCPs and specialists. The survey asked how often PCPs receive feedback from specialists. The responses were as follows: 49.1% (always or often), 38% (sometimes), and 13% (rarely or never). The result of this survey revealed significant problems with PCPs receiving feedback from specialists.

During onsite interview, Plan personnel stated the referral tracking logs were reviewed through random audits. However, the Plan personnel did not mention how often referral logs were audited or how often unused referrals were tracked by individual PPGs.

#### **RECOMMENDATIONS:**

- Develop a system to effectively track PCPs' referrals.
- Develop a policy and procedure to ensure that all specialist referrals are tracked to completion and that PCPs receive feedback.
- Implement a process to track open or unused referrals.
- Develop a policy and procedure to define timeframes for audits of referral logs.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

1.4

**PRIOR AUTHORIZATION APPEAL PROCESS**

**Appeal Procedures:**

There shall be a well-publicized appeals procedure for both providers and patients.  
2-Plan Contract A.5.2.E

**SUMMARY OF FINDINGS:**

The Contract requires the Plan to have a well-publicized appeal procedure for both providers and members. Although the Plan has a well-publicized appeal procedure, it did not address the high rate of overturned appeals due to insufficient information in the original prior authorization. This resulted in unnecessary delays to members receiving medically necessary services.

The Contract requires the Plan to ensure the individual reviewing the appeal is not involved in any prior decision related to the appeal. Policy and Procedure Number AG-007: *Appeals Process for Members* describes the procedures and requirements regarding appeals. AG-007 states an Appeal review is conducted by one or more peer reviewers: "Who were not involved in the Adverse Determination that is the subject of the Appeal..." "Who are not subordinates of any person involved in the adverse determination that is the subject of the Appeal," although, "The practitioner who made the initial adverse determination may review the case and overturn the previous decision."

The verification study included 30 Provider and Member appeals consisting of medical and pharmaceutical services. All were resolved appropriately and within required timeframes. However, review of individual cases revealed multiple issues: 20 overturned appeals lacked information on initial submission (prior to reaching the appeal level) of the prior authorization service requested. Once additional information was received and reviewed (at the appeal level), the decision was to overturn the appeal resulting in unnecessary delays of medically necessary services. In one case, the physician who made the initial adverse determination also reviewed the case for a second time, which resulted in overturning the previous decision. This practice of using a physician who participated in previous decisions related to the appeal process did not comply with Contract requirements.

**RECOMMENDATIONS:**

- Implement process to address high rate of overturned appeals due to lack of sufficient information in the original prior authorization.
- Amend L.A. Health Care Plan Policy and Procedure Number AG-007: *Appeal Process for Members* to ensure the physician reviewing the appeal is not involved in any prior decisions related to the Appeal.

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

**CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE**

**2.1**

**CASE MANAGEMENT AND COORDINATION OF CARE: WITHIN AND OUT-OF-PLAN**

**Case Management and Coordination of Services:**

Contractor shall ensure the provision of Comprehensive Medical Case Management to each Member.

Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside the Contractor's provider network.

2-Plan Contract A.11.1

**Out-of-Plan Case Management and Coordination of Services:**

Contractor shall implement procedures to identify individuals who may need or who are receiving services from out of plan providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for services...

2-Plan Contract A.11.5

**SUMMARY OF FINDINGS:**

The Contract requires the Plan to ensure provision of Comprehensive Medical Case Management Services to each member. These services are provided through either Basic or Complex Case Management activities based on the medical needs of the member. The Contract requires the Plan to maintain procedures for monitoring the coordination of care, including but not limited to all medically necessary services delivered within and outside the Plan's provider network. The Contract also requires the Plan to identify individuals who may need or who receive services from out of plan providers or programs to ensure coordination and joint case management for services.

Five medical records for case management and coordination of care were reviewed for the verification study; the Plan did not comply with the preceding contract requirements. The Plan delegated access to care to PPGs, but the Plan did not ensure proper oversight of the delegated activities. Two medical records did not have documentation of coordination of care and case management. Case Management notes showed the Plan lacked documentation of referrals and monitoring procedures on coordination of care among PCPs, specialists, and Regional Centers. The Plan lacked procedures to identify members who may need or who receive services from out-of-plan providers or programs to ensure joint case management of services.

**RECOMMENDATIONS:**

- Improve oversight of delegated case management services to ensure contract requirements are met.
- Improve and document monitoring procedures on coordination of care between PCPs, specialists or Regional Centers.
- Improve procedures to identify members who may need or who are receiving services from out-of-plan providers and programs in order to ensure coordinated joint case management of services.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

2.2

### CALIFORNIA CHILDREN'S SERVICES (CCS)

#### **California Children's Services (CCS):**

Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program... (as required by Contract)

Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program... for the coordination of CCS services to Members.

2-Plan Contract A.11.9.A, B

#### **SUMMARY OF FINDINGS:**

The Contract requires the Plan to implement policies and procedures for identifying and referring children with California Children's Services (CCS)-eligible conditions to the local CCS program. The Plan is also required to have a Memorandum of Understanding (MOU) between Los Angeles County Department of Public Health and CCS. The Contract states that once eligibility for the CCS program is established, the Plan shall ensure the coordination of services and joint case management between its PCPs, CCS specialty providers, and the local CCS program.

Based on available report and verification study, the Plan did not ensure coordination of services and joint case management between PCPs and other local agencies or programs. The Plan also did not properly identify members needing referrals to other agencies or programs.

The *Utilization Management Annual Report and Evaluation 2013* described the result of a supplemental file review conducted by the UM Oversight program. The result showed inadequate CCS co-management and collaboration of care between PCPs and local CCS program or other agencies. Eight (40%) PPGs reviewed by the Plan fell below the performance goal of 90%. The audits identified barriers in the PCPs' ability to obtain reports from paneled specialists and institutions, as well as the member receiving routine coordinated care.

Fourteen medical records were reviewed for the verification study. Medical records for 11 members did not show documentation of coordination of services between the PCP and CCS specialty providers or other agencies. Nine members were over 21 years old and no longer eligible for CCS. Medical records for these members lacked documentation of any referral or follow up with the other State programs such as Genetically Handicapped Persons Program for which members 21 years and older might qualify.

#### **RECOMMENDATIONS:**

- Improve monitoring and tracking of coordination of care for CCS-eligible Members.
- Improve the system of obtaining CCS data.
- Implement procedures to improve referral system to other agencies for Members needing referrals.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

2.3

### EARLY INTERVENTION SERVICES / DEVELOPMENTAL DISABILITIES

#### **Services for Persons with Developmental Disabilities:**

Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.

Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall participate with Regional Center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services, which need to be provided to the Member.

Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers... for the coordination of services for Members with developmental disabilities.

2-Plan Contract A.11.10.A, C, E

#### **Early Intervention Services:**

Contractor shall develop and implement systems to identify children who may be eligible to receive services from the Early Start program and refer them to the local Early Start program... Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation.

2-Plan Contract A.11.11

### **SUMMARY OF FINDINGS:**

The Contract requires the Plan to implement procedures of a system to identify children with Developmental Disabilities (DD) who may be eligible to receive services from the Regional Centers or Early Start program. The Plan and its Plan Partners have an MOU with the local regional centers for coordination of services for members with DD. The Plan maintains a designated liaison to coordinate with each regional center within the Plan's service area.

In a verification study, all 13 medical records indicated members received appropriate services for their medical conditions. However, eight medical records did not show coordination of services between the PCP and the local programs (Regional Center or Early Start Program). The medical records also lacked documentation demonstrating the Plan's designated coordinator coordinated care between the Plan and other agencies.

### **RECOMMENDATIONS:**

- Develop a more effective monitoring system to ensure coordination of care occurs between the PCPs or specialists and local programs (Regional Center or Early Start program).
- Ensure coordination of care is documented by the Plan's designated coordinator.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

2.4

INITIAL HEALTH ASSESSMENT

**Provision of Initial Health Assessment:**

Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22, CCR, Sections 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.

2-Plan Contract A.10.3.A

Provision of IHA for Members under Age 21

For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 60 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.

For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.

2-Plan Contract A.10.5

IHAs for Adults, Age 21 and older

- 1) Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.
- 2) Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes, but is not limited to:
  - a) blood pressure,
  - b) height and weight,
  - c) total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,
  - d) clinical breast examination for women over 40,
  - e) mammogram for women age 50 and over,
  - f) Pap smear (or arrangements made for performance) on all women determined to be sexually active,
  - g) chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,
  - h) screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and,
  - i) health education behavioral risk assessment.

2-Plan Contract.A.10.6

Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement.

2-Plan Contract A.10.3.D

**SUMMARY OF FINDINGS:**

The Contract requires the Plan to cover and ensure the provision of an Initial Health Assessment (IHA) within the required timeframes. The Contract also requires the Plan to ensure members receive comprehensive age-appropriate assessments or screenings on a periodic basis. The Plan shall document follow-up attempts for members who missed their scheduled IHA. However, based on the Plan's 2013 Annual Report and a verification study, the Plan did not provide IHAs to all newly enrolled members within the required timeframes. The Plan did not ensure that members received comprehensive age-appropriate assessments on a periodic basis. The Plan also failed to comply with its own policy which is to document two attempts to contact a member who missed their scheduled IHA.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

Policy and Procedure Number UM-135: *Initial and Periodic Health Assessments* states new members receive an IHA within 120 or 60 calendar days of enrollment depending on the member's age. UM-135 describes the provision of health assessments or screenings for pediatrics and adults on a periodic basis. UM-135 also states, "When a Member misses a scheduled appointment for an IHA, the Plan and the PPGs/PCPs are to follow up on newly enrolled Members with two documented attempts to reschedule the IHA appointment."

The Plan's 2013 Annual Report revealed the provision of IHA remained an outlier for 2013. Twenty-one contract groups surveyed fell below the performance goal of 90%. This result showed IHA as a preventive service was not received timely by members. Several of the PPGs reported the reason for non-compliance was due to members' high no-show rate and/or missed scheduled appointments. The Annual Report indicated the Plan continued to reach-out to new enrollees but needed a sustained effort from the PCPs and PPGs to work effectively.

The verification study showed four medical records exceeded the required timeframe for members to have their IHA. Seven medical records lacked documentation to support a comprehensive assessment making the office visit ineligible to qualify as an IHA. These records also lacked documentation supporting comprehensive age-appropriate assessments or screenings. For thirty-five members the Plan sent the IHA reminder letter; however there was no documentation demonstrating the required two follow-up attempts. In addition, 10 members lacked documentation indicating any attempts of contact or reminder to schedule their IHA.

**RECOMMENDATIONS:**

- Develop a system to improve oversight of PPGs' compliance to IHA.
- Ensure completion of the IHA within the required timeframe.
- Ensure members receive comprehensive age-appropriate assessments on a periodic basis.
- Ensure documentation of the required follow-up attempts to contact members who missed their scheduled appointments.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1

APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

**Appointment Procedures:**

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

2-Plan Contract A.9.3.A

**Prenatal Care:**

Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.

2-Plan Contract A.9.3.B

**Monitoring of Waiting Times:**

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments...

2-Plan Contract A.9.3.C

**SUMMARY OF FINDINGS:**

The Contract requires the Plan to implement and maintain procedures for members to obtain appointments for various types of health care and assessments. The Contract also requires the Plan to monitor wait times in providers' offices and response time to members' telephone calls. Based on available survey reports and other information, the Plan did not comply with the required timeframe for members to receive appointments for routine care, routine specialty care referral, and urgent care. In addition, the Plan did not comply with the required timeframe to answer member calls.

Policy and Procedure Number QI-030: *Assessment of Appropriate Access to Covered Services* describes the requirements for the availability and accessibility of health care services including wait times to obtain appointments. To monitor providers' compliance with access health care standards, the Plan uses the Annual Access and Availability Report, Consumer Assessment of Health Care Providers and Systems Survey (CAHPS) results, administrative grievances, and telephone system records. To monitor waiting times in providers' offices, the Plan conducts a Field Site Review (FSR) every three years. To monitor obtaining appointments, the Plan conducts the Annual Access to Care Survey.

The Plan's Quality Oversight Committee (QOC) minutes dated March 24, 2014 includes data from the 2013 Member Satisfaction Report. The Plan monitors member satisfaction by an annual assessment of all complaints, appeals, and surveys. Results are summarized in the Member Satisfaction Report and the Access and Availability Report. Based on these reports, Access to Care complaints remains the highest percentage of members' complaints. Approximately 50% of the Access to Care complaints concern delays in service, authorization, and specialty access/availability.

The 2013 Child Medicaid CAHPS scores and goals showed the following: *Getting Needed Care* score was 72.87%, the goal was 87%; *Getting Care Quickly* score was 67.27%, the goal was 75%. According to the Plan's own report, members did not receive care adequately and timely.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

The 2013 Annual Access and Availability Report Summary revealed members did not obtain appointments within the required timeframes. The Report indicates the Plan did not meet the work plan performance goals for PCP routine or well care, urgent care, and specialty care referral as follows:

- Routine well care physician exam was 87% against the 95% compliance goal (up to 10 business days to get appointment)
- Urgent care appointment timeframe was 93% against the 98% compliance goal (up to 48 hours to get appointment)
- Routine specialty referral appointment was 92% against the 95% compliance goal (up to 15 business days to get appointment)

**RECOMMENDATIONS:**

- Implement actions and processes to meet appointment timeframe requirements for routine, urgent, and specialty care.
- Improve measures to monitor the effectiveness of actions taken in meeting timeframe requirements.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

3.2

### URGENT CARE / EMERGENCY CARE

#### Urgent Care:

Members must be offered appointments within the following timeframes:

- 1) Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;
  - 2) Urgent appointment for services that do require prior authorization – within 96 hours of a request;
- 2-Plan Contract A.9.4.B

#### Emergency Care:

Contractor shall ensure that a Member with an emergency condition will be seen on an emergency basis and that emergency services will be available and accessible within the Service Area 24-hours-a-day.

2-Plan Contract A.9.7

Contractor shall have, as a minimum, a designated emergency service facility, providing care on a 24-hour-a-day, 7-day-a-week basis. This designated emergency services facility will have one or more physicians and one nurse on duty in the facility at all times.

2-Plan Contract A.6.5

### SUMMARY OF FINDINGS:

The Contract requires the Plan to ensure members are offered appointments and receive urgent or emergency care within the required timeframes. The Contract also requires the Plan to have a designated emergency facility providing care 24 hours a day, seven days a week. However, based on available reports and survey, the Plan did not meet the performance goals for urgent care appointments and wait times.

Policy and Procedure QI-030: *Assessment of Appropriate Access to Covered Services* stipulates that members must be offered urgent care appointments within 48 hours of a request not requiring prior authorization and within 96 hours of a request requiring prior authorization. QI-030 also describes the requirements for the availability and accessibility of health care services appropriate for members' medical condition in a timely manner, which includes wait times to obtain appointments. QI-030 includes guidelines for urgent care, emergency care, and after-hours care standards for access to quality comprehensive health care services 24 hours a day, seven days a week.

The Plan monitors urgent care appointment procedures annually to determine if policies and procedures are being followed by the PPGs and PPs. However, the 2013 Annual Access and Availability Report summary indicates the Plan did not meet work plan performance goals: The PCP urgent care appointment compliance rate was 93% against a work plan performance goal of 98%. The Specialty Care Physician (SCP) urgent care appointment with no authorization had a compliance rate of 63%, while the one with authorization had a compliance rate of 73%. Both fell short of the Plan's required 100% performance goal.

Results of the 2013 Medi-Cal Adult and Child CAHPS survey also indicated the Plan did not meet performance goals for SCP urgent care appointment wait times. The average waiting time for SCP urgent care appointment was 12.8 days (307.2 hours) for adults and 7.4 days (177.6 hours) for children, which did not meet established standards of up to 48 hours with no authorization, and up to 96 hours if authorization is needed.

### RECOMMENDATIONS:

- Implement actions and processes to meet timeframe requirements for urgent care appointments and wait times.
- Improve measures to monitor the effectiveness of actions taken in meeting timeframe requirements.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

3.3

### TELEPHONE PROCEDURES / AFTER HOURS CALLS

#### Telephone Procedures:

Contractor shall require providers to maintain a procedure for triaging Members' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.

2-Plan Contract A.9.3.D

Contractor shall maintain the capability to provide Member services to Medi-Cal Members or potential Members through sufficient assigned and knowledgeable staff

2-Plan A.13.2.A

#### After Hours Calls:

At a minimum, Contractor shall ensure that a physician or an appropriate licensed professional under his/her supervision will be available for after-hours calls.

2-Plan Contract A.9.3.E

### SUMMARY OF FINDINGS:

The Contract requires the Plan's providers to maintain a procedure for triaging members' telephone calls, providing telephone medical advice, and accessing telephone interpreters if needed by members. The Contract also requires the Plan to maintain the capability to provide member services through adequate and qualified staff. The Contract also requires the Plan to ensure availability of a physician or covering practitioner for after-hours calls. Although the Plan maintains procedures for the preceding requirements, the Plan did not consistently answer member calls within the required time frame. The Plan also did not meet its performance goal for after-hours telephone procedures.

Policy and Procedure Number QI-009: *Nurse Advice Line* states in summary the Plan will maintain a 24 hours a day, seven days a week Nurse Advice Line to assist members in making informed decisions regarding their care. Telephone triage or screening services appropriate for members' condition shall not exceed 30 minutes. Policy and Procedure Number QI-030: *Assessment of Appropriate Access To Covered Services* describes the requirements for the availability and accessibility of health care services in a timely manner including the speed of answering members' telephone calls within 30 seconds, call abandonment rate, call return time by staff at providers office, and after-hours care coverage.

For after-hours care, PCPs are required by contract to provide 24 hours, 7 days a week coverage to members. PCPs must have either an answering device or an answering service to accept member calls when the office is closed. An automated system or a live party answering service must be able to connect the caller to the PCP or covering practitioner or offer a call-back from the PCP (or covering practitioner) within 30 minutes.

The Plan uses a telephone system called CISCO to measure the accessibility of the Member Services Department. The system indicates phone calls were answered within 30 seconds 67% of the time. This did not meet the Plan's goal of 85%. The McKesson Monthly Summary found that the average speed of answering the Nurse Advice Line phone calls was greater than 30 seconds for four months in the review period.

The 2013 Annual Access and Availability Report Summary indicates the Plan did not meet the work plan performance goals for after-hours telephone procedures. The Plan scored a 70% overall compliance rate, which did not meet the Plan's goal of 92%. The 92% goal was not met for the following functions:

- emergency instructions, 82%
- ways of reaching doctor or an on-call practitioner, 82%
- length of time for the on-call practitioner to call back (1 – 30 minutes), 88%
- recorded instructions on how long it will take for the on-call practitioner to call back (1 – 30 minutes), 80%.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

**RECOMMENDATIONS:**

- Implement actions to improve answering calls within 30 seconds for Member Services and Nurse Advice Line.
- Implement actions to improve after-hours telephone access to physicians.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

**CATEGORY 4 – MEMBER’S RIGHTS**

**4.1**

**GRIEVANCE SYSTEM**

**Member Grievance System and Oversight:**

Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c).

2-Plan Contract A.14.1

Contractor shall implement and maintain procedures... to monitor the Member’s grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858.... (as required by Contract)

2-Plan Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).

2-Plan Contract A.14.3.A

**SUMMARY OF FINDINGS:**

The Contract requires the Plan to implement, maintain, and monitor a member Grievance System. Although the Plan has policies and procedures for members to file a grievance, the Plan failed to fulfill its contractual responsibility to report grievances to its committees and Board of Governors during the audit period. Based on a verification study, the Plan failed to address several issues related to the Grievance System.

During onsite interview, the Plan stated the Grievance and Appeal (G&A) process is not delegated to its PPGs but it is delegated to the PPs. The Plan monitors the G&A process through annual oversight of the PPs. If the Plan Partner scores less than 100% on the clinical grievance delegation oversight audit, a Corrective Action Plan (CAP) is required. Results of these audits are reported internally to the Regulatory Affairs and Compliance, UM Committee and subsequently, to the QOC. Inquiries or complaints resolved within 24 hours are listed in the Inquiry Log; these are not forwarded to the G&A department and are not reviewed in an aggregated manner. The G&A department generates a report; this report consists of five categories that are tabulated but provides limited data, which makes it difficult to perform quality improvement. The current Track and Trend report lacks sufficient details to allow for aggregation and analysis of the grievances to identify the root causes.

The G&A Department forwards the bi-monthly Track and Trend report to the UM Committee. If the Track and Trend report includes grievances filed against a provider, it is forwarded to the Peer Review and Quality Improvement Committee (QIC). However, no data was submitted to the UM Committee, QOC and Board of Governors from August 2013 through April 2014. This did not comply with the reporting requirements as specified under the Contract.

For the verification study, 60 grievances were reviewed; all of the acknowledgement letters were issued to the complainants within five days. Fifty-eight grievances were resolved within 30 calendar days from the date of receipt. However, review of individual cases revealed multiple issues: The resolution letters in two cases did not address all issues filed with the grievances. In three cases, there were incomplete evaluations of the grievances due to inadequate request of medical records from physician’s office, emergency room, and hospital records. In another three cases, the medical reasoning by the Medical Director was not documented thoroughly. In two cases, members with chronic disease who were lost due to lack of follow up were not reviewed for potential quality improvement. There was no documentation that these cases were considered for quality improvement through care coordination and possible placement into case management.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

**RECOMMENDATIONS:**

- Ensure and implement a procedure for systemic aggregation and analysis of grievance data and use it for Quality Improvement.
- Ensure the Board of Governors routinely receives written progress reports from the QI Committee describing actions taken, progress in meeting QI System objectives, and accomplishments.
- Ensure the Plan addresses all complaints in the resolution letter.
- Ensure medical records are obtained and reviewed for pertinent dates of service relevant to the grievance.
- Ensure medical reasoning by the Medical Director is well documented.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

4.3

### CONFIDENTIALITY RIGHTS

#### Members' Right to Confidentiality

Contractor shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

- 1) Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the network.
- 2) Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain Member's consent prior to release of confidential information, unless such consent is not required pursuant to Title 22 CCR Section 51009.

2-Plan Contract A.13.1.B

#### Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:

Contractor agrees:

B. Safeguards—To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains or transmits on behalf of DHCS; and to prevent use or disclosure of PHI other than as provided for by this Contract....

H. Notification of Breach—During the term of this Agreement:

- 1). Discovery of Breach. To notify DHCS immediately by telephone call plus e-mail or fax upon the discovery of breach of security of PHI in computerized form if the PHI was, or is reasonably believed to have been, acquired by an unauthorized person; or within 24 hours by e-mail or fax of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of this Contract...
- 2). Investigation of Breach. To immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, to notify the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer...
- I. Notice of Privacy Practices. To produce a Notice of Privacy Practices (NPP) in accordance with standards and requirements of HIPAA, the HIPAA regulations, applicable State and Federal laws and regulations, and Section 2.A. of this Exhibit...

2-Plan Contract G.3.B, H, and I

### SUMMARY OF FINDINGS:

The Contract requires the Plan to implement and maintain policies and procedures to ensure members' information confidentiality rights. The Contract also requires the Plan to maintain administrative, physical, and technical safeguards that reasonably and appropriately protect members' confidentiality rights. The Contract requires the Plan to notify DHCS Medi-Cal Managed Care Division (MMCD) Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer within 24 hours of discovery of breach.

The Plan's Policy and Procedure Number RACH-007: *Authorization for Use or Disclosure of Protected Health Information* establishes the Plan's privacy and security of members' Protected Health Information (PHI). The Plan may disclose PHI without member authorization as permitted by federal and state law. Policy and Procedure Number RACH-003: *Process Requests to Access Protected Health Information* addresses the Plan's requests by a member to inspect and/or obtain a copy of their member PHI maintained by the Plan. The Plan also has established policies and procedures defining guidelines related to fax safeguards for transmitting PHI via fax and physical safeguards (e.g., printers, copiers, paper based PHI) ensuring that printers and copiers are properly safeguarded to prevent the inappropriate use or disclosure of PHI.

Policy and Procedure Number RACH-009: *Incident Notification and Mitigation of Inappropriate Use or Disclosure of PHI* establishes that for suspected breach incidents, the Privacy Officer (PO) or designee will notify DHCS immediately. PO or designee will notify DHCS within 24 hours by email or fax of any unauthorized use or disclosure of PHI in violation. Notification is to be provided to the DHCS MMCD Contracting Officer, the DHCS Privacy Officer,

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

and to the DHCS Information Security Officer. The Privacy Officer or designee, within 72 hours of discovery, will provide a preliminary investigation report, with as much information as is known about the incident.

For the verification study, 10 cases were investigated within 72 hours of discovery. Two cases were not reported within the required 24-hour timeframe. The initial notification of breach for all 10 cases were only sent to the DHCS Privacy Officer and DHCS MMCD Contract Manager, but not submitted to the DHCS Information Security Officer as required by the contract.

**RECOMMENDATIONS:**

- Ensure the initial notification of PHI breach is submitted to DHCS personnel within the required time 24-hour timeframe.
- Ensure all suspected and actual breaches are reported to the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

**CATEGORY 5 – QUALITY MANAGEMENT**

**5.5**

**MEDICAL RECORDS**

**Medical Records**

**A. General Requirement**

Contractor shall ensure that appropriate medical records for Members, pursuant to Title 28, CCR, Section 1300.80(b)(4), Title 42 United States Code (USC) Section 1396a(w), 42 CFR 456.111 and 42 CFR 456.211, shall be available to health care providers at each encounter in accordance with Title 28, CCR Section 1300.67.1(c) and Title 22 CCR Section 53861 and MMCD Policy Letter 02-02.

**B. Medical Records**

Contractor shall develop, implement and maintain written procedures pertaining to any form of medical records:

- 1) For storage and filing of medical records including: collection, processing, maintenance, storage, retrieval identification, and distribution.
- 2) To ensure that medical records are protected and confidential in accordance with all Federal and State law.
- 3) For the release of information and obtaining consent for treatment.
- 4) To ensure maintenance of medical records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).

**C. On-Site Medical Records**

Contractor shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each site.

**D. Member Medical Record**

Contractor shall ensure that a complete medical record is maintained for each Member in accordance with Title 22 CCR Section 53861, that reflects all aspects of patient care, including ancillary services, and at a minimum includes:

- 1) Member identification on each page; personal/biographical data in the record.
- 2) Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.
- 3) All entries dated and author identified; for Member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment.
- 4) The record shall contain a problem list, a complete record of immunizations and health maintenance or preventive services rendered.
- 5) Allergies and adverse reactions are prominently noted in the record.
- 6) All informed consent documentation, including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6, if applicable.
- 7) Reports of emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions.
- 8) Consultations, referrals, specialists', pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.
- 9) For medical records of adults, documentation of whether the individual has been informed and has executed an advanced directive such as a Durable Power of Attorney for Health Care.
- 10) Health education behavioral assessment and referrals to health education services.

2-Plan Contract A.4.13.A, B, C, D

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

### **SUMMARY OF FINDINGS:**

The Contract requires the Plan to implement and maintain policies and procedures that ensure appropriate medical records for members are available to health care providers at each encounter and these records are properly stored and safeguarded. The Contract requires the Plan to ensure a complete medical record is maintained for each member, including reports of emergency care provided by contracted providers and hospital discharge summaries for all hospital admissions.

The Plan's Policy and Procedure Number FSR-024: *Medical Record Standard* and Number UM-127: *Confidential Protected Health Information and Medical Information: Request of, Use of, Release of, and Storage of* establish guidelines for medical record keeping including storage, access, and confidentiality standards. FSR-024 also communicates standards for the availability, administration, and maintenance of medical records. The Service Agreement between the Plan and contracted PPGs includes Section 1.19: *Medical Records Maintenance*, which requires the PPG to maintain current, detailed, organized, and comprehensive records.

The Plan performs Medical Record Review (MRRs) during Facility Site Review process to ensure PCPs are in compliance with medical record documentation. The MRR conducted in 2013 did not include review of emergency care and hospital discharge summary, which is a violation of the contract requirement.

In a verification study, 18 medical records did not meet the criteria for a complete medical record. The incomplete records lacked the required Formatting Criteria (i.e., individual personal biographical information, emergency contact, identification of PCP), Documentation Criteria (i.e., Advance Health Care Directive information not offered, chronic problems and/or significant conditions not listed), Coordination and/or Continuity of Care Criteria (i.e., History of Present Illness not documented and unresolved/continuing problems not addressed in subsequent visit).

### **RECOMMENDATIONS:**

- Ensure the Plan review of emergency care and hospital discharge summaries during FSR.
- Ensure the Plan maintains a complete medical record for each member.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

5.6

### INFORMED CONSENT

#### Informed Consent

Contractor shall ensure that a complete medical record is maintained for each Member in accordance with Title 22 CCR Section 53861, that reflects all aspects of patient care, including ancillary services, and at a minimum includes: ... All informed consent documentation, including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6, if applicable.

2-Plan Contract A.4.13.D.6

Contractor shall ensure that informed consent is obtained from Medi-Cal enrollees for all contraceptive methods, including sterilization, consistent with requirements of Title 22 CCR Sections 51305.1 and 51305.3.

2-Plan Contract A.9.9.A.1

#### SUMMARY OF FINDINGS:

The Contract requires the Plan to ensure that a complete medical record is maintained for each member. The Plan shall ensure an informed consent for all contraceptive methods is obtained from members. The Contract requires the Plan to have an established informed consent process that includes completion of form PM 330, the provision of a Department-issued booklet, and the required timeframe between the consent signature of a member and date of the sterilization procedure.

Policy and Procedure Number UM-201: *Sterilization: Informed Consent and Requirements for Completion of Form PM 330* indicates members age 21 years and older have access to sterilization procedures performed either by network or out-of-network providers. UM-201 states that the person obtaining the consent should be provided a copy of PM 330 and booklet on sterilization published by the DHCS. Family planning services including sterilizations do not require prior authorization unless the procedure requires inpatient hospitalization. For sterilization by in-network providers, Informed Consent (IC) is obtained from members and documented on a completed PM 330 form prior to the sterilization procedure. UM-201 identifies conditions to be met prior to performing a sterilization procedure (i.e., IC is obtained from the member at least 30 days, but not more than 180 days between the date of the written IC and the date of the sterilization).

The verification study showed one claim did not have a form PM 330 and three PM 330s did not have signatures of physicians performing the surgery. One service had a conflicting date of service noted on PM 330 and operative note. Another service was performed less than the required 30-day time limit between the date on the consent form and the date of the procedure. Members were not provided a copy of a booklet on sterilization (published by the Department).

#### RECOMMENDATIONS:

- Educate providers and the Plan's Claims Department on the proper completion of form PM 330.
- Ensure the Plan obtains a completed sterilization Informed Consent form (PM 330) submitted with claims.
- Educate providers about the requirement of documentation regarding sterilization and provision of a Department-issued booklet to each member.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

**CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY**

6.4

**PROVIDER TRAINING**

**Medi-Cal Managed Care Provider Training:**

Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, provider, Member and/or other healthcare professionals. Contractor shall conduct training for all providers within ten (10) working days after the Contractor places a newly contracted provider on active status....

2-Plan Contract A.7.5

**SUMMARY OF FINDINGS:**

The Contract requires the Plan to ensure that all providers receive training within ten working days after the provider is placed on active status with the Plan

Policy and Procedure Number PNO-024: *Provider Network Training* states that Provider Network Operations (PNO) shall provide initial provider network training to its contracted provider network within 10 calendar days after placing a newly contracted provider on active status.

The Plan delegates provider training and orientation responsibility to PPGs to train their new Providers. *Services Agreement between L.A. Care Health Plan and Contracted PPG, Section 1.34: PPG Service Requirements* states that the PPG shall develop and conduct an orientation program for all new physicians within the first 10 business days from their affiliation effective date (including, but not limited to PCPs and Affiliated Providers). PPGs shall have a training and education program for PCPs, Affiliated Providers, and office staff, and conduct an on-going provider training and education as set forth in the Provider Manual. The Plan monitors and conducts audits of its PPGs to ensure compliance with the new provider training from their affiliation effective date.

For the verification study, 18 new providers did not receive the training within 10 working days of being placed on active status. Four providers received this training prior to being placed on active status.

**RECOMMENDATION:**

Ensure all new providers receive training within 10 working days after being placed on active status.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

6.5

**FRAUD AND ABUSE**

**Fraud and Abuse Reporting**

Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse....

- 1) Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract.
- 2) Contractor shall provide effective training and education for the compliance officer and all employees.
- 3) Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines.
- 4) Fraud and Abuse Reporting—Contractor shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, Members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity...
- 5) Tracking Suspended Providers—Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs....

2-Plan Contract E.2.26.B

**SUMMARY OF FINDINGS:**

The Contract requires the Plan to report all cases of suspected fraud and/or abuse to DHCS within 10 working days from the date the allegation is received.

Policy and Procedure Number RAC-014: *Special Investigation Unit: Initiating and Conducting Investigation for Fraud, Waste and Abuse Cases* specifies the Plan's process for the prevention and reporting of suspected wasteful, fraudulent, or abusive activity. In addition, DHCS shall be informed of all suspected fraud and/or abuse within 10 working days of receipt of allegation.

The verification study showed the Confidential Medi-Cal Complaint Reports (MC609) for six cases were not submitted to the DHCS Program Integrity Unit within the required timeframe of 10 working days.

**RECOMMENDATION:**

Ensure that all suspected fraud and/or abuse cases are reported to the DHCS Program Integrity Unit within the required 10 working days.

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

**L.A. Care Health Plan**

Contract Number: 03-75799  
State Supported Services

Audit Period: April 1, 2013  
Through  
March 31, 2014

Report Issued: March 11, 2015

## TABLE OF CONTENTS

I.	INTRODUCTION .....	1
II.	COMPLIANCE AUDIT FINDINGS .....	2

## INTRODUCTION

This report presents findings of the L.A. Care Health Plan's compliance and its implementation of the State Supported Services contract with the State of California. The State Supported Services contract covers abortion services for L.A. Care Health Plan (the Plan).

The onsite audit was conducted from June 25, 2014 through July 9, 2014. The audit covered the review period from April 1, 2013 through March 31, 2014 and consisted of review of documents supplied by the Plan.

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

PLAN: L.A. Care Health Plan

AUDIT PERIOD: April 1, 2013 through March 31, 2014

DATE OF AUDIT: June 25, 2014 through July 9, 2014

**STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS**

**Abortion**

*Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:*

*Current Procedural Coding System Codes\*: 59840 through 59857*

*HCFA Common Procedure Coding System Codes\*: X1516, X1518, X7724, X7726, Z0336*

*\*These codes are subject to change upon the Department of Health Services' (DHS) implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.*

*State Supported Services Contract Exhibit A.1*

**SUMMARY OF FINDINGS:**

Abortion is a sensitive service covered by the Medi-Cal program without prior authorization for out-patient abortions; however, for in-patient abortions, prior authorization is required. The Plan must provide Members pregnancy termination procedures from in-or-out of network providers. The Member EOC Handbook informs Members that minors do not need parent consent to access pregnancy termination services.

The Plan's policies and procedures inform providers that Members can obtain sensitive services without prior authorization through any qualified provider in-or out of network. Members, 12 years and older, can self-refer or directly access all sensitive and confidential services exempt from prior authorization without parental consent and they also can get abortion services through their primary care physicians or from other qualified out-of-network providers. In addition, Members are advised to call Member Services to ensure scheduling of sensitive services as needed when a provider has a moral objection to providing family planning services such as abortions.

The Plan's Managed Health Care Information System is responsible for the review and revisions, as changes are identified, of the various billing codes. Currently, the Plan's billing system include the updated claim payment codes as follow: Current Procedural Terminology (CPT) Codes 59840 through 59857; Healthcare Common Procedure Coding System (HCPCS) Codes A4649 with Modifier U1 and/or U2 in addition to ICD-9-CM Diagnosis Codes 632, 634.00 – 634.92, 635.00 – 635.92, V61.7; HCPCS S0199 (Medical Abortion), S0190 (Mifepristone [RU-486]), and S0191 (Misoprostol), as billable codes for abortion services.

The Plan provides or arranges to provide, to eligible Members, the required State Supported Services listed above. Based on the review no deficiencies were found.

**RECOMMENDATION:**

Not Applicable