

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

REPORT ON THE CAL MEDICONNECT AUDIT OF

**Local Initiative Health Authority for Los Angeles
County dba L.A. Care Health Plan**

2021

Contract Number: H8258
Three-Way Contract (Cal MediConnect)

Audit Period: July 1, 2020
Through
June 30, 2021

Report Issued: February 3, 2022

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I. INTRODUCTION

Local Initiative Health Authority for Los Angeles County dba L.A. Care Health Plan (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. The Plan obtained its Knox-Keene license in April 1997.

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

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

As of June 2021, the Plan's total enrollment for its CMC line of business was 18,800.

II. EXECUTIVE SUMMARY

This report presents the audit findings of DHCS medical review audit for the period of July 1, 2020 through June 30, 2021. The review was conducted from July 12, 2021 through July 23, 2021. The audit consisted of document reviews, verification studies, and interviews with Plan personnel.

An Exit Conference was held on January 6, 2022. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. On January 21, 2022, the Plan submitted a response after the Exit Conference. The results of our evaluation of the Plan's response are reflected in this report.

The audit evaluated five categories of performance: Utilization Management, Continuity of Care (COC), Access and Availability of Care, Enrollee Rights, and Quality Management (QM).

The prior DHCS CMC audit for the period of July 1, 2017 through June 30, 2018, was issued on February 7, 2019. This audit examined for compliance and to determine to what extent the Plan implemented their prior Corrective Action Plan (CAP). The prior year CAP was closed as of May 16, 2019. A finding denoted as a repeat finding is an uncorrected deficiency substantially similar to that identified in the previous audit.

The summary of the findings by category is as follows:

Category 1 – Utilization Management

The Plan is required to make authorization decisions in a timely manner for expedited and standard Service Authorization Requests (SAR). The Plan had extensive delays in processing SAR regarding member clinical and related health care service needs, including urgent and routine outpatient prior authorizations, inpatient or concurrent (urgent and routine) prior authorization requests, and retrospective requests.

The Plan is required to provide a Notice of Appeal Resolution (NAR) letter in a timely manner for expedited and standard appeals. The Plan did not process, resolve, and issue NAR letters to numerous enrollees.

The Plan is required to provide enrollees with the "Your Rights" attachment approved by DHCS. The Plan did not update the State Fair Hearing timeframe on the Your Rights and Responsibilities statement attached to the NAR letters.

The Plan is required to notify enrollees in writing when misclassified appeals and/or grievances occurred. The Plan did not notify enrollees in writing when grievances were misclassified.

Category 2 – Continuity of Care

The Plan is required to notify enrollees 30 calendar days before the end of the COC period regarding the transition of care process at the end of the COC period. The Plan did not follow contractual requirements and its policy in notifying enrollees 30 calendar days before the end of the COC period.

The Plan is required to ensure the COC criteria for new enrollees includes at least one visit with specialists within the last 12 months. The Plan's criteria for COC eligibility incorrectly required at least two visits with specialists within the last 12 months.

The Plan is required to notify Primary Care Physicians (PCPs) of any new enrollee who has not completed a Health Risk Assessment (HRA) within the required time period. The Plan's policy does not notify PCPs of any new enrollee who has not completed a HRA within the time period.

Category 3 – Access and Availability of Care

The Plan is required to ensure its Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) providers are enrolled in the Medi-Cal program. The Plan did not ensure its NEMT and NMT providers were enrolled in the Medi-Cal program.

Category 4 – Enrollee Rights

The Plan is required to use the "Your Rights" attachment approved by DHCS. The Plan did not update the State Fair Hearing timeframe on the Your Rights and Responsibilities statement attached to member resolutions. This is a repeat finding.

The Plan is required to provide written communication to enrollees regarding the grievance resolution. The Plan did not provide resolution letters to numerous enrollees.

The Plan is required to provide the grievance resolution letter within 30 calendar days after the Plan receives the grievances. The Plan did not ensure the grievance resolution letters were mailed out to enrollees within the required timeframe.

The Plan is required to develop and implement an effective compliance plan to accurately provide disenrollment information and assistance to enrollees. The Plan did not have an effective compliance plan to appropriately provide disenrollment information and assistance to enrollees.

Category 5 – Quality Management

No findings were noted for the review period.

III. AUDIT SCOPE / PROCEDURES

SCOPE:

This audit was conducted by DHCS– Medical Review Branch to ascertain that Medicaid-based medical services provided to the Plan’s CMC enrollees complied with the contract, the federal and state laws and regulations, and applicable guidelines.

PROCEDURE:

DHCS conducted a review of the Plan from July 12, 2021 through July 23, 2021. The audit included a review of the Plan’s 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 the Plan administration and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization requests: 19 prior authorization (five pharmacy and 14 medical) requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to enrollees and providers.

Appeals: 29 appeals were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to enrollees and providers.

Category 2 – Continuity of Care

HRA and Interdisciplinary Care Plan: 15 files were reviewed for care coordination, completeness, and compliance with the required timeframes.

Category 3 – Access and Availability of Care

NEMT and NMT: 20 records from 15 NEMT providers and 16 records from 11 NMT providers were verified to confirm compliance with NEMT and NMT requirements.

Category 4 – Enrollee Rights

Grievance procedures: 86 grievances including 37 quality of care and 49 quality of service were reviewed for timely resolution, response to complainant, and appropriate medical decision-making.

Category 5 – Quality Management

Potential quality issue: 17 cases were reviewed for reporting, investigation, and remediation.

Provider training: 25 newly contracted providers were reviewed for timely program training.

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

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CATEGORY 1 - UTILIZATION MANAGEMENT

1.2 Prior Authorization Review Requirements

1.2 Processing Service Authorization Requests

The Plan is required to make authorization decisions in a timely manner for expedited and standard requests. The Plan must make a decision and provide notice within five working days for standard authorization decisions and within 72 hours for expedited service authorization decisions after receipt of the request for service. The Plan can obtain a possible extension not to exceed 14 additional calendar days when criteria are met. (*Three-Way Contract § 2.11.5.6 and § 2.11.7*)

The Plan’s decision to approve, modify, or deny based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the time period for review, shall be made in a timely fashion appropriate for the nature of the enrollee’s condition, not to exceed five business days from the Plan’s receipt of the information reasonably necessary and requested by the Plan to make the determination. In cases where the review is retrospective, the directions shall be communicated to the individual who received services, or to the individual’s designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. (*Health and Safety Code, section 1367.01(h)(1)*)

The Plan’s policy and procedure, *MMUM-047: Initial Organization Determination - Medical Management - Utilization Management (reviewed 8/6/2020)*, states Plan notifies member regarding the routine (non-expedited or standard) Organization Determinations within 14 calendar days of receipt of the request and within 72 hours for expedited determination. The Plan will extend the 72 hours deadline by up to 14 calendar days when it is needed.

Finding: The Plan delayed processing and decisions for inpatient, pre-service, and retrospective authorization requests. As a result, the Plan was severely impacted by significant delays in providing members with their clinical and related health care service needs.

The Plan indicated the primary root cause for these deficiencies was related to the conversion to a new platform for Utilization Management functions beginning early April,

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2021. The Plan also attributed the delays to a lack of staff training, needed system improvements, and a higher than normal volume of inpatient requests due to Covid-19.

Failure to ensure timely processing of Service Authorization Requests can severely and adversely impact the ability of enrollees to obtain medically necessary and indicated services.

Recommendation: Revise and implement procedures to ensure Service Authorization Requests are processed within the required timeframes.

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1.3 Appeal Procedures

1.3.1 Notice of Appeal Resolution Letter Sent to Enrollees

The Plan is required to provide enrollee a Notice of Resolution, as expeditious as the enrollee's health condition requires, not exceeding 30 calendar days from the day contractor receives the appeal, or in the case of an expedited appeal within 72 hours. (*Three-Way Contract § 2.15.3.5*)

A NAR is a formal letter informing a beneficiary that an Adverse Benefit Determination has been overturned or upheld. The timeframes for resolving standard appeals is 30 days from the time the Plan receives the appeal and 72 hours for expedited appeals. (*All Plan Letter (APL) 17-006 – Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments (5/9/2017)*)

The timeframes for resolving standard appeals is 30 days from the time the Plan receives the appeal and 72 hours for expedited appeals. The Plan is required to provide written Notice of Resolution. (*CFR, Title 42, section 438.408(b)*)

The Plan's policy and procedure, *AG-007: Appeals Process for Members - Appeals and Grievances (reviewed 1/9/2019)*, states the Plan resolves standard concurrent, pre- and post-service appeals within 30 calendar days, and expedited appeals within 72 hours. The Appeals Department contacts the member or authorized representative to inform them of the resolution made, followed by a written resolution letter for expedited appeals, or provide a written communication for standard appeals.

Finding: The Plan did not process, resolve, and issue NAR letters within the required timeframes for expedited and standard appeals.

The Plan attributed the deficiency to the escalation in grievance and appeal case volume per staff. Furthermore, the Plan identified the need for greater senior management oversight of workload, as well as improving supporting and reporting tools. In addition, the transition to a work from home environment caused by COVID-19 also played a role.

Failure to notify enrollees of their appeal resolution could negatively impact their care, service, and ability to exercise their enrollee rights.

Recommendation: Develop and implement procedures to ensure timely appeal resolutions and notifications.

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1.3.2 Appeal Resolution Letter Template

The enrollee has a right to request a State Hearing no later than 120 calendar days from the date of receipt of the Managed Care Plan's (MCP) written appeal resolution and instructions on how to request a State Hearing. (*APL 17-006 – Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments (5/9/2017)*)

The Plan's policy and procedure, *AG-007: Appeals Process for Members - Appeals and Grievances (reviewed 1/9/2019)*, states a State Fair Hearing request must be filed within 120 days from the NAR.

Finding: The Plan did not provide its enrollees with an accurate State Fair Hearing time frame on the "Your Rights & Responsibilities as a Plan Member" template attached to member appeal resolution letters.

The verification study identified eight out of 29 appeal resolution letters where the enrollee was sent inaccurate notices. The information did not include the need to exhaust the Plan's internal appeals process and the State Fair Hearing request must be filed within 120 days from the NAR.

The Plan did not send the Plan's vendor, the corrected "Your Rights & Responsibilities as a Plan Member" statement for use.

Providing incorrect information may result in enrollees requesting a State Fair Hearing prior to exhausting the Plan's internal appeals process or missing a State Fair Hearing timeframe.

Recommendation: Develop and implement procedures to provide enrollees correct "Your Rights & Responsibilities as a Plan Member" information.

1.3.3 Notification to Enrollees of Appeal-Grievance Classification

The Contract requires the Plan to proceed with appeals relating to Medi-Cal covered benefits and services pursuant to the laws and regulations governing Medi-Cal appeals. Appeals related to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare appeals. (*Three-Way Contract § 2.15.2*)

If the Plan misclassifies a grievance as an appeal or an appeal as a grievance, the Plan is required to notify the enrollee in writing that the case was misclassified and will be

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handled through the Plan's appropriate grievance or appeal process. (*Medicare Managed Care Manual, Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, 30.1 & 50.11*)

The Plan's policy and procedure, *MMUM-047: Initial Organization Determination – Medical Management – Utilization Management (reviewed 8/6/2020)*, states upon discovery of a misclassified appeal as grievance, the Plan will notify the enrollee in writing that the complaint was misclassified and will be handled through the appeals process.

Finding: The Plan did not comply with appeal and grievance misclassification requirements.

The Plan did not maintain enrollee notification templates or send letters to enrollees when grievances were misclassified and should have been handled through the appeals process.

During the interview, the Plan acknowledged that they did not carry out these specific requirements or elements of their policy.

If the Plan does not notify enrollees regarding misclassification of appeals and grievances as required, enrollee's rights can be impacted.

Recommendation: Revise and implement procedures to ensure enrollees are notified of misclassified appeals and grievances.

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CATEGORY 2 – CONTINUITY OF CARE

2.1	Case Management and Coordination of Care
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2.1.1 Notification before the End of Continuity of Care Period

The Plan is required to comply with all current and applicable Duals Plan Letters (DPLs) issued by DHCS. (*Three-Way Contract § 2.15.2*)

The Plan is required to notify enrollees 30 calendar days before the end of the COC period about the process that will occur to transition their care through new providers. (*DPL 16-002 – Continuity of Care (7/5/2016)*)

The Plan’s policy and procedure, *MMUM-023: Continuing Coverage of Services By Non-Participating Providers For New Cal MediConnect (CMC) Members – Medical Management – Utilization Management (reviewed 11/7/2019)*, states the Plan must notify enrollees 30 calendar days before the end of the COC period about the process that will occur to transition their care through new providers.

Finding: The Plan did not send a letter to enrollees 30 days before the end of the COC service period.

During the interview, the Plan stated enrollees were informed about COC services including the time period of the end of the COC services in the COC services approval letter. However, the Plan did not send an additional letter to enrollees 30 days prior to the end of the COC services.

During the interview, the Plan stated this deficiency was due to lack of monitoring and leadership of the staff. The Plan recognized the deficiency and noted the need to train staff in order to implement and monitor their policy and procedure.

If the Plan does not notify enrollees regarding ending of the COC services as required, the Plan can potentially impede enrollees from having enough time to make decisions in selecting alternative providers and accessing services timely.

Recommendation: Develop and implement procedures to ensure compliance with requirements regarding notifying enrollees 30 days before the end of the COC period.

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2.1.2 Continuity of Care Information

The Plan is required to offer COC with out-of-network providers to all CMC beneficiaries if all three circumstances exist. One of them is a beneficiary has seen an out-of-network PCP or a specialty care provider at least once during the 12 months prior to the date of his or her initial enrollment in the Medicare-Medicaid Plan for a non-emergency visit. (DPL 16-002 – Continuity of Care (7/5/2016))

The Plan's policy and procedure, *MMUM-023: Continuing Coverage of Services By Non-Participating Providers For New Cal MediConnect (CMC) Members – Medical Management – Utilization Management (reviewed 11/7/2019)*, states the Plan offers COC with out-of-network providers to all CMC members if all six circumstances exist. The beneficiary has seen an out-of-network PCP or a specialty care provider at least once during the 12 months prior to the date of his or her initial enrollment in the Plan for a non-emergency visit.

Finding: The Plan's 2021 Enrollment Kit for CMC enrollee and Telephonic Outbound Call Script included incorrect COC eligibility criteria information.

The Plan's Kit and Script both stated new enrollees must be seen by specialists at least twice in the last 12 months instead of once as required. The Plan stated that if the COC request is for an out-of-network specialist, it may not be approved due to the request being screened by a Sales or Customer Service Representative. The Plan acknowledged that the Sales or Customer Service Representative may apply the incorrect COC eligibility criteria. There were no procedures in place to alert the Plan regarding the deficiency of the Enrollment Kit and Outbound Script.

When the Plan uses stricter criteria for COC eligibility, members may be improperly denied care with their existing health care providers.

Recommendation: Revise and implement procedures to ensure the Plan complies with COC requirements.

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2.2 Health Risk Assessment / Individualized Care Plan

2.2.1 Notification to PCP for Health Risk Assessment Completion

The Plan is required to notify PCPs of enrollment of any new enrollee who has not completed a HRA within the required time period and whom the Plan has been unable to contact. The Plan shall encourage PCPs to conduct outreach to their enrollees and to schedule visits. (*Three-Way Contract § 2.8.2.5*)

The Plan’s policy and procedure, *HS-CM-013: Health Risk Stratification and Assessment for Seniors and Persons with Disabilities (SPD) and CalMediConnect (CMC) – Care Management (reviewed 11/7/2020)*, states Plan will mail out a blank HRA to enrollees in the event the enrollee remains unable to be contacted by the end of the specified regulatory timeline.

Finding: The Plan did not notify PCPs’ enrollees who had not completed HRAs within the required time period.

A review of ten sample files revealed that the Plan did not send notification letters to PCPs for nine files. In addition, Plan policy HS-CM-013 did not include the above contractual requirements.

During the interview, the Plan acknowledged that it did not consistently follow its own process of sending a notification to inform PCPs about enrollees who had not completed the HRAs.

If the Plan does not notify PCPs regarding enrollees who have not completed HRAs as required, this may impede enrollees from accessing healthcare timely, which may lead to poor health outcomes.

Recommendation: Revise and implement policies and procedures to ensure notification of PCPs with respect to HRA completion.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.8	Non-Emergency Medical and Nonmedical Transportations
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3.8.1 Enrollment of Transportation Providers

Pursuant to CFR, Title 42, section 438.602(b), the Plan is required to ensure that all network providers are enrolled with DHCS as Medicaid providers consistent with the provider screening, disclosure, and enrollment requirements of CFR, Title 42, section 55, subparts B and E. (*Three-Way Contract § 2.9.5*)

The Plan is required to provide transportation services pursuant to the Contract, applicable law including but not limited to Welfare & Institutions Code, section 14132(ad) and the requirements in applicable current and future DPLs. (*Three-Way Contract Appendix A.3.2.2*)

The Plan is responsible for ensuring that their delegated entities and subcontractors (including transportation providers) comply with applicable state and federal laws and regulations, contractual requirements, and other requirements set forth in DHCS guidance, including DPLs. (*DPL 18-001 – Non-Emergency Medical and Non-Medical Transportation Services (4/26/2018)*)

Effective November 29, 2019, all NMT enrollment applicants are required to apply using the Provider Application and Validation for Enrollment (PAVE) system. Transportation providers who are not currently enrolled in Medi-Cal, but want to provide NMT services are required to complete and submit the Medi-Cal Provider e-form Application and all supporting documentation using the PAVE system. (*Welfare and Institutions Code, section 14132(ad)(8) - Medi-Cal Benefit Added: Non-Medical Transportation*)

The Plan’s Vendor Management Desk Level Procedure, *PNM-CRM DEPT Vendor Mgmt Desk Level Procedure: Non-Emergency Medical Transportation (NEMT) & Non-Medical Transportation (NMT) Oversight & Monitoring Program – Vendor*, states regarding provider screening and enrollment, vendor will demonstrate contracting efforts in terms of how many contracts are pending in the pipeline. Additionally, vendor will report on where each subcontracted vendor is at in the credentialing process and provide status of their Medi-Cal enrollment.

Finding: The Plan did not ensure its subcontractors were enrolled in the Medi-Cal program.

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A review of the NEMT and NMT provider paid claims sample, along with the Medi-Cal provider list, revealed one out of 15 NEMT providers used was not enrolled in the Medi-Cal program at the time the services were rendered. Additionally, one out of the 11 NMT providers was also not enrolled.

During the interview, the Plan stated that they did not communicate the requirement to subcontractors or vendors. While the Plan has the policy and process in place for screening the subcontractors or vendors, the Plan's staff did not follow the screening process.

If the Plan does not ensure transportation providers are enrolled in the Medi-Cal program, this may result in enrollees receiving inadequate and unsafe transportation services.

Recommendation: Develop and implement procedures to ensure the Plan's transportation providers are enrolled in the Medi-Cal program.

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CATEGORY 4 – ENROLLEE RIGHTS

4.1	Grievance System
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4.1.1 Enrollee Rights Attachment

The enrollee has a right to request a State Hearing no later than 120 calendar days from the date of receipt of the MCP’s written appeal resolution and instructions on how to request a State Hearing. (*APL 17-006 – Grievance and Appeal Requirements and Revised Notice Templates and “Your Rights” Attachments (5/9/2017)*)

The Plan’s policy and procedure, *AG-007: Appeals Process for Members – Appeals and Grievances (reviewed 1/9/2019)*, states a State Hearing request must be filed within 120 days from the NAR.

Finding: The Plan did not provide its enrollees with an accurate State Fair Hearing timeframe on the “Your Rights & Responsibilities as a Plan Member” attachment. The template states, “you can ask for a Fair Hearing at any time”.

The verification study identified 25 out of 86 grievance cases where inaccurate information was sent to CMC enrollees. The notice states, “you can ask for a Fair Hearing at any time”. The information did not include State Fair Hearing request must be filed within 120 days from the NAR.

The Plan did not send the Plan’s vendor, the corrected “Your Rights & Responsibilities as a Plan Member” statement for use.

If written member information is not updated with new timeframes on when to file a State Hearing, members may be prevented from exercising their rights to file in a timely manner.

This is a repeat of prior audit finding **4.1.1 State Fair Hearing Time Frames**.

Recommendation: Develop and implement procedures to provide enrollees correct “Your Rights & Responsibilities as a Plan Member” information.

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4.1.2 Grievance Resolution Letters

The Plan is required to respond, electronically, verbally, or in writing, to each enrollee grievance within a reasonable time, but no later than 30 days after the Plan receives the grievances. (*Three-Way Contract § 2.14.2.1.3.3*)

The Plan is required to notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee's health status, but no later than 30 days after the date the organization receives the verbal or written grievance. (*CFR, Title 42, 422.564(e)*)

Timeframes for resolving grievances and sending written resolution to the beneficiary are delineated in both federal and state regulations. The Plan shall comply with the State's established timeframe of 30 calendar days for grievance resolution. (*APL 17-006 – Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments (5/9/2017)*)

The Plan's policy and procedure, *AG-008: Grievance Process for Members – Appeals and Grievances (reviewed 4/19/2019)*, states the Plan's Appeals and Grievance Department will provide communication regarding the resolution verbally and/or via written communication.

Finding: The Plan did not send grievance resolution letters to enrollees.

The Plan stated they did not generate resolution letters. A review of the Plan's grievance verification log revealed that the Plan failed to notify enrollees with written resolution. The Plan attributed the deficiency to the escalation in grievance and appeal case volume per staff. Furthermore, the Plan identified the need for greater senior management oversight of workload, as well as improving supporting, and reporting tools. In addition, the transition to a work from home environment caused by COVID-19 also played a role.

If the Plan does not send enrollees grievance resolution letters, this could negatively impact their care, service, and rights.

Recommendation: Develop and implement procedures to ensure the issuance and mailing of grievance resolution letters to enrollees.

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4.1.3 Grievance Resolution Letter Timeframe

The Plan is required to respond, electronically, verbally, or in writing, to each enrollee grievance within a reasonable time, but no later than 30 days after the Plan receives the grievances. (*Three-Way Contract § 2.14.2.1.3.3*)

Timeframes for resolving grievances and sending written resolution to the beneficiary are delineated in both federal and state regulations. The Plan shall comply with the State's established timeframe of 30 calendar days for grievance resolution. (*APL 17-006 – Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments (5/9/2017)*)

The Plan is required to notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee's health status, but no later than 30 days after the date the organization receives the verbal or written grievance. (*CFR, Title 42, section 422.564(e)*)

The Plan's policy and procedure, *AG-008: Grievance Process for Members – Appeals and Grievances (reviewed 4/19/2019)*, states the Plan sends a written resolution letter to enrollee or authorized representative within 30 calendar days upon reaching a resolution.

Finding: The Plan did not send grievance resolution letters to enrollees within the 30 calendar days after the Plan receives the grievances.

A review of standard grievance files revealed that the Plan did not send grievance resolution letters within 30 calendar days for two cases.

The Plan attributed the deficiency to the escalation in grievance and appeal case volume per staff. Furthermore, the Plan identified the need for greater senior management oversight of workload, as well as improving supporting reporting tools. In addition, the transition to a work from home environment caused by COVID-19 also played a role.

If the Plan does not adhere to the required timeframes for resolving grievances, this may negatively impact enrollees' care, service, and rights.

Recommendation: Develop and implement procedures to ensure the grievance resolution letters are mailed out to enrollees within 30 calendar days.

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4.1.4 Enrollment and Disenrollment Information to Enrollees

The Plan is required to develop and implement an effective compliance program that must include measures that prevent, detect, and correct noncompliance. (*Three-Way Contract § 2.1.4*)

Enrollees can elect to disenroll from CMC Plan or the Demonstration at any time. (*Three-Way Contract § 2.3.2.4*)

The Plan shall process enrollment and disenrollment transactions according to the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance. (*Three-Way Contract § 2.3.1.5.9*)

The Plan shall have processes and procedures in place to refer enrollees that request disenrollment from the Plan to the DHCS Enrollment Broker. (*Three-Way Contract § 2.3.2.2*)

The Plan is subject to rules governing marketing and enrollee communications. (*Three-Way Contract § 2.17.1.1*)

The Plan is required to adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS' program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse. (*CFR, Title 42, section 422.503(b)(4)(vi)*)

The Plan may not mislead, confuse, or provide materially inaccurate information to current or potential enrollees. (*CFR, Title 42, section 422.2262*)

The Plan's policy and procedure, *SM-020: Oversight and Monitoring of Sales Representatives and Contracted Agents – Sales & Marketing (reviewed 10/5/2020)*, states the Plan's Sales and Marketing Department follows applicable rules and regulations as well as the guidelines set forth by the CMS, DHCS, and the California Health Benefit Exchange regarding the oversight and monitoring of Sales Representatives.

The Plan's policy and procedure, *SM-023: Sales & Marketing Violations and Complaints – Sales & Marketing (reviewed 9/30/2020)*, states the Plan's Sales and Marketing shall ensure that all sales violations or complaints are investigated and closed properly to reduce compliance risk and to impact the beneficiary's experience in a positive way.

❖ COMPLIANCE AUDIT FINDINGS ❖

Plan: Local Initiative Health Authority for Los Angeles County
dba L.A. Care Health Plan
Contract: Cal MediConnect
Audit Period: July 1, 2020 through June 30, 2021
Date of Audit: July 12, 2021 through July 23, 2021

Finding: The Plan did not have effective policies and procedures for enrollment and disenrollment transactions including enrollees that request disenrollment. In addition, the Plan did not have an effective compliance program for its Sales and Enrollment Departments.

The Plan received a CMS Warning Letter and Request for a Business Plan which was issued on July 19, 2021. According to the Plan's responses to CMS, the Plan acknowledged that they did not currently have a comprehensive compliance program or efficient oversight of the Enrollment Sales Department.

Grievance files were reviewed for enrollment and disenrollment transactions.

- Two of eight files were related to disenrollment issues, enrollees were unable to disenroll from the Plan due to inadequate information that was provided about the disenrollment process.
- In four of eight files, enrollees were unaware of being enrolled in the CMC program and were not able to follow-up with their previous physicians.

Grievance files indicated that CMC enrollees were enrolled without their consent. In addition, the Plan did not provide adequate disenrollment information to enrollees when they expressed dissatisfaction or requested to disenroll.

If the Plan does not have a comprehensive compliance program or efficient oversight of the Enrollment Sales Department, this may negatively impact enrollees' care, service, and rights.

Recommendation: Develop and implement policies and procedures to ensure that the Plan provides enrollees correct enrollment and disenrollment information.