DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

RANCHO CUCAMONGA – SECTION

REPORT ON THE MEDICAL AUDIT OF LOCAL INITIATIVE HEALTH AUTHORITY FOR LOS ANGELES DBA L.A. CARE HEALTH PLAN FISCAL YEAR 2023-24

Contract Numbers: 04-36069 and 23-30232

Audit Period: February 1, 2023 — January 31, 2024

Dates of Audit: June 10, 2024 — June 21, 2024

Report Issued: January 16, 2025

DHCS

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I. INTRODUCTION

Local Health Initiative 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 a Knox-Keene license in April 1997.

The Plan provides managed care health services to Medi-Cal beneficiaries under the provision of the California Welfare and Institutions Code (W&I) section 14087.3. The Plan is a separately constituted health authority governed by the Los Angeles County Board of Supervisors. The Plan utilizes a "Plan Partner" model, under which the Plan contracts with three health plans through capitated agreements. The Plan Partners are Anthem Blue Cross, Blue Shield of California Promise Health Plan, and Kaiser Foundation Health Plan, Inc. The Plan began providing coverage directly to Medi-Cal members under the Plan's line of business Medi-Cal Care Los Angeles (MCLA) in 2006. In the direct line of business, the Plan contracts with 27 Participating Physician Groups that receive a capitated payment for each member. In addition, the Plan utilizes 35 delegates to provide services to Medi-Cal members.

As of January 2024, the Plan's total enrollment by product lines are as follows: 2,240,506 Medi-Cal (Plan Partners and MCLA), 19,235 Dual Eligible Special Needs Plan, 157,271 L.A. Care Covered California, 53 L.A. Care Covered CA Direct, and 48,375 PASC-SEIU. As of January 31, 2024, the Plan's delegates enrollment population is 2,871,414.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of February 1, 2023, through January 31, 2024. The audit was conducted from June 10, 2024, through June 21, 2024. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on December 18, 2024. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On January 2, 2025, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

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

The prior DHCS medical audit for the period of July 1, 2021, through January 31, 2023, was issued on November 3, 2023. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation of the prior year 2023, Corrective Action Plan.

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan is required to ensure that the UM program includes an established specialty referral system to track and monitor referrals requiring Prior Authorization (PA) through the Plan. The Plan's UM program did not track and monitor specialty referrals requiring PA through the Plan.

The Plan is required to obtain a member's written consent when a representative acting on behalf of a member files an appeal with the Plan either verbally or in writing. The Plan did not ensure that members' written consent was obtained for authorized representation to file appeals on the members' behalf.

The Plan is required to ensure the UM program utilizes established evaluation criteria and standards to approve or deny services. The Plan did not ensure the delegate Los Angeles, Department of Health Services (LA DHS), utilized established evaluation criteria and standards to approve or deny services.

Category 2 – Case Management and Coordination of Care

The Plan is required to complete an Initial Health Assessment (IHA) for new members within 120 calendar days of enrollment. The Plan did not ensure the completion of an IHA for new members within 120 days of enrollment.

The Plan is required to ensure network providers provide verbal or written anticipatory guidance for lead exposure to the parents or guardians of a child member. The Plan did not ensure anticipatory guidance was provided to parents or guardians of age-appropriate members.

The Plan is required to ensure the provision of a Blood Lead Screening (BLS) test to members at ages one and two. The Plan did not ensure the provision of BLS tests to child members at ages one and two and did not document the reason for not performing a BLS test in the child's medical record.

Category 3 – Access and Availability of Care

The Plan is required to ensure a copy of the Physician Certification Statement (PCS) form is on file for all members receiving Non-Emergency Medical Transportation (NEMT) services. The Plan did not ensure a PCS form was on file for all members receiving NEMT services.

Category 4 – Member's Rights

The Plan is required to ensure discrimination grievances are investigated, resolved, and submitted to the DHCS Office of Civil Rights (OCR). The Plan did not investigate, resolve, and submit discrimination grievances to DHCS OCR.

The Plan is required to ensure that all grievances related to medical Quality of Care (QOC) issues must be immediately submitted to the Plan's Medical Director (MD) for action. The Plan did not ensure that all QOC grievances were immediately submitted to the Plan's MD for action.

The Plan is required to maintain a full-time MD whose responsibilities shall include resolving grievances related to medical QOC. The Plan's MD did not resolve QOC grievances.

The Plan is required to provide grievance resolution letters that contain a clear and concise explanation of the Plan's decision. The Plan did not send members grievance resolution letters with clear and concise explanation of the Plan's decisions.

The Plan is required to obtain a member's written consent when a representative acting on behalf of a member files a grievance with the Plan either verbally or in writing. The Plan did not ensure that members' written consent was obtained for authorized representation when a grievance was filed on the member's behalf.

Category 5 – Quality Management

The Plan is required to conduct training for all network providers within ten working days after the Plan places a newly contracted network provider on active status. The Plan did not train newly contracted network providers within ten working days after being placed on active status.

Category 6 – Administrative and Organizational Capacity

The Plan is required to notify the DHCS Medi-Cal Managed Care Program/Program Integrity Unit (PIU) within ten working days of removing a suspended, excluded, or terminated provider from the provider network. The Plan did not notify PIU within ten working days of removing a suspended, excluded, or terminated provider from the Plan’s provider network.

The Plan is required to ensure complete and accurate encounter data to DHCS for all items and services furnished to members. The Plan did not ensure subcontractors and network providers submitted accurate encounter data for services furnished to a member for directed supplemental physician payments.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted the audit to ascertain that medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

DHCS conducted an audit of the Plan from June 10, 2024, through June 21, 2024, for the audit period of February 1, 2023, through January 31, 2024. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, 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

PA Requests: 29 PA requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Appeal Process: 25 PA appeals were reviewed for appropriate and timely adjudication.

Delegation of UM: 17 PA requests from LA DHS were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

IHA: 32 medical records were reviewed to confirm completion of IHAs, and 20 medical records were reviewed for completion of BLS tests.

Behavioral Health Treatment: 20 medical records were reviewed for compliance with behavioral health treatment requirements.

Category 3 – Access and Availability of Care

NEMT: 21 records were reviewed to confirm compliance with NEMT requirements.

Non-Medical Transportation: 27 records were reviewed to confirm compliance with Non-Medical Transportation requirements.

Category 4 – Member's Rights

Grievance Procedures: 25 QOC and 31 quality of service grievance cases were reviewed for timely resolution, appropriate response to complainant, and submission to the appropriate level for review. Seven exempt grievances and 17 inquiry calls were reviewed for proper classification and routing to the appropriate level for review.

Category 5 – Quality Management

Quality Improvement System: 15 potential quality issue cases were reviewed for timely evaluation and effective action taken to address improvements.

Provider Training: 20 new provider training records were reviewed for timeliness.

Category 6 – Administrative and Organizational Capacity

Fraud, Waste, and Abuse: 14 fraud and abuse cases were reviewed for proper reporting of suspected fraud, waste, and abuse to DHCS within the required timeframe.

Encounter Data/Proposition 56 Directed Payments: 12 claims were reviewed to verify if the Plan reported complete, accurate, reasonable, and timely encounter data.

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

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management

1.1 Utilization Management Program

1.1.1 Referral Tracking

The Plan shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of medically necessary covered services. The Plan is responsible to ensure that the UM program includes: an established specialty referral system to track and monitor referrals including those that require PA through the Plan. *(Contract, Exhibit A, Attachment 5 (1))*

Plan policy, *MMUM-002 Referral Request Management* (effective 12/21/2023), described how the Plan maintains current processes and guidelines for reviewing requests for authorization and for making UM determinations, as well as subsequent referral tracking.

Finding: The Plan did not ensure the UM program included a specialty referral system that tracked and monitored specialty referrals requiring PA.

Plan policy MMUM-002 stated the Plan maintains current processes and guidelines for reviewing requests for authorization and making UM determinations, as well as subsequent referral tracking. While the Plan policy MMUM-002 states the process to ensure the review of all incoming PA requests, the Plan did not demonstrate operationalizing written processes for specialty referral tracking, monitoring, or for documenting contract required metrics such as authorized, denied, deferred, or modified referrals.

During the interview, the Plan acknowledged not having a fully developed referral tracking system and that the Plan is in the process of developing a system to track open, unused, and incomplete specialty referrals.

This is a repeat of the prior year finding - 1.1.2 Referral Tracking

If the Plan does not track and monitor specialty referrals requiring PA, it may result in a delay in members receiving medically necessary services. Ultimately, the lack in tracking

and monitoring specialty care referrals may lead to substandard medical care and member harm.

Recommendation: Revise and implement policies and procedures and effectuate systems and processes to track and monitor specialty referrals requiring PAs.

1.3 Prior Authorization Appeal Process

1.3.1 Written Consent for Appeals

A member, or a provider or an authorized representative acting on behalf of a member and with the member's written consent, may file an appeal with the Plan either orally or in writing. *(Contract Exhibit A, Attachment 14 (1)(A))*

If state law permits and with the written consent of the member, a provider or an authorized representative may request an appeal or file a grievance on behalf of a member. *(Code of Federal Regulations (CFR), Title 42, section 438.402 (c)(1)(ii))*

Plan policy, *AG-007 Appeals Process for Members* (effective 12/15/2023), stated to be considered a representative of the member, written documentation must be received by the Plan. If the member has requested that someone other than themselves act on their behalf a valid Appointment of Representative (AOR) form is required. The Appeals and Grievance (A&G) Department will make at least three attempts to contact the member. Each attempt will be documented in the Plan's system. If the Plan does not receive the completed or valid AOR form or an equivalent within 30 calendar days, the case will be dismissed.

Finding: The Plan did not ensure members' written consent was obtained for authorized representation to file appeals on the members' behalf.

Plan policy AG-007 stated that if anyone other than the member files an appeal or grievance, the A&G Department will require that an AOR form be completed. However, the Plan did not obtain the members' AOR form when purported authorized representatives filed appeals on the members' behalf.

The verification study revealed the Plan processed seven appeals without the member's written consent. During the audit period, the Plan's process was to make three attempts to the member if an AOR was not on file. After three attempts, the Plan would proceed with initiating the appeal even though the AOR was not on file from the member. This is

a deviation from the Plan's policy AG-007, which stated that if the Plan does not receive the completed or valid AOR within 30 calendar days, the case will be dismissed.

During the interview, the Plan stated that a new process was implemented in January 2024, requiring an AOR to be received and signed by the member before an appeal is initiated. However, implementation did not occur until after the audit period. Therefore, the DHCS was unable to verify the implementation and effectiveness of the new process.

This is a repeat of the prior year finding - 1.3.1 Written Consent for Appeals

When the Plan does not obtain a member's written consent prior to processing an appeal on their behalf, a member's right to autonomy is at risk and their protected health information may be compromised, which may lead to unauthorized medical care decisions being made on their behalf and unauthorized access to their medical records.

Recommendation: Revise and implement procedures to ensure the Plan obtains a member's written consent for authorized representation prior to processing an appeal on behalf of the member.

1.5 Delegation of Utilization Management

1.5.1 Delegate Utilization Management Medical Decision Making

The Plan is required to maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum: 1) Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill responsibilities, 2) Ensures subcontractor meets standards set forth by the Plan and DHCS, and 3) Includes continuous monitoring, evaluation, and approval of delegated functions. *(Contract, Exhibit A, Attachment 4 (6)(B)(1)(2)(3))*

The Plan is responsible to ensure that the UM program includes established criteria for approving, modifying, deferring, or denying requested services. The Plan shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. *(Contract, Exhibit A, Attachment 5 (1)(D))*

The Plans are responsible for ensuring that delegates comply with all applicable state and federal laws and regulations, and contract requirements. *(All Plan Letter (APL) 23-006, Delegation and Subcontractor Network Certification)*

The Plan and any entity the Plan contracts with for services that include utilization review or UM functions shall comply with California Health and Safety Code (H&S Code) section 1367.01. In addition, the Plan is required to have written policies and

procedures establishing the process by which the Plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for Plan members. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. *(H&S Code section 1367.01(a) and (b))*

Plan policy, *EPO-001 Clinical Monitoring of Delegated Functions* (effective 08/30/2023), stated that the Plan remains accountable for and has appropriate structures and mechanisms to oversee delegated activities even if it delegates all or part of these activities. At a minimum, the Plan includes the continuous monitoring and evaluation of delegated functions.

Plan delegate, LA DHS policy, *205.039 Services Requiring Prior Authorization and Prior Authorization Exclusion* (effective 09/22/2023), stated that PA is not required for specialty care services rendered within the LA DHS delivery system. Additionally, to ensure the clinical appropriateness of these specialty care services referrals, LA DHS communicates with providers and utilizes triage software, Electronic Consultation (eConsult). Specialty care services submitted through eConsult will require PA when the Primary Care Providers (PCP) checked the UM referral box.

LA DHS, *Utilization Management Program Description 2023* (11/2023), stated LA DHS utilizes written UM decision-making criteria/guidelines that are objective and based on sound medical evidence. Individual patients and their clinical circumstances vary; therefore, guidelines provide a framework for clinical decisions and all final decision making is determined by licensed professionals under the direction of trained physician specialists. Approved criteria include the following:

- State and federal regulatory criteria found in the Medi-Cal Provider Manual includes information on the Medi-Cal services, programs and claim reimbursement.
- Health Plans' clinical policies as applicable
- LA DHS Clinical Policies and Expected Practices
- InterQual Guidelines

Finding: The Plan did not ensure that LA DHS complied with UM PA requirements to utilize established evaluation criteria and standards to approve, modify, defer, or deny services.

In November 2022, due to the prior year's audit finding, LA DHS implemented a PA system for specialty care referrals to ensure that the process for reviewing, approving, modifying, delaying, or denying requests complied with contractual requirements. LA DHS established a process for providers to request PAs for specialty referrals through the online eConsult system. The eConsult system allows the PCP and the specialist to engage in a dialogue to ensure the clinical appropriateness of service referrals. According to LA DHS policy *205.039*, a PA is not required for specialty care services rendered within the LA DHS delivery system if mutually agreed upon by the specialist provider in eConsult. In addition to this dialogue, the PCP may request a PA by checking the UM referral box. A UM decision is initiated and the process to review, approve, modify, delay, or deny the PA requests is required. However, during this process, the Plan did not ensure that LA DHS fully complied with UM PA requirements for approving or denying services.

A verification study of the delegate's data from February 1, 2023, to January 31, 2024, was conducted to assess the impact of the recent PA system changes and to evaluate overall compliance with PA requirements. During the audit period, LA DHS processed 17 UM PA requests. Of these, the use of criteria for medical necessity determination was inconsistent. The study revealed that for seven PA requests, the Plan did not follow the criteria attached to the medical record as a guideline for making the medical decision to approve or deny the PA request. Although, the seven PA requests were ultimately denied for not meeting the criteria, the review revealed that if the Plan had adhered to the guidelines attached to the medical records, these PA requests would not have been denied. Therefore, LA DHS did not apply consistent criteria or guidelines that support clinical principles and processes in making PA decisions.

In the interview, the Plan stated based on the prior year's finding, changes were implemented to improve procedures for processing PA requests. The initial change of embedding a PA request in the existing eConsult system was the Plan's first attempt to address deficiencies noted in the prior year's finding. The Plan is aware that the initial changes were not enough to rectify the deficiency and plans to implement new procedures moving forward.

If the Plan does not effectively oversee the compliance of UM systems and processes, the members' ability to receive timely medically necessary services may be impacted, which could result in adverse health outcomes and member harm.

Recommendation: Revise and implement UM delegation oversight processes to ensure that LA DHS is compliant with the utilization of established evaluation criteria and standards to approve, modify, defer, or deny service.

COMPLIANCE AUDIT FINDINGS

Category 2 – Case Management and Coordination of Care

2.1 Basic Case Management, California Children's Services, Early Intervention/Developmental Disabilities, Initial Health Assessment Management

2.1.1 Initial Health Assessment

The Plan shall cover and ensure the provision of an IHA (complete history and physical examination) in compliance with California Code of Regulations (CCR), Title 22, section 53851(b)(1) to each new member within timelines stipulated in Provisions 5 and 6 of the Contract. *(Contract, Exhibit A, Attachment 10 (3)(A))*

The IHA must be completed within 120 days of enrollment for new members and must continue to include a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screenings or services and health education, and the diagnosis and plan for treatment of any diseases. *(California Advancing and Innovating Medi-Cal (CalAIM): Population Health Management Policy Guide, 08/2023)*

Plan policy, *QI-047 Initial Health Appointment* (effective 11/29/2023), requires Plan network providers to cover and ensure the provision of a complete IHA, either in person or virtually, to each new member within 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics for ages two and younger whichever is less. New Plan members who choose their current Medi-Cal PCP as their new Plan PCP still need an IHA to be completed within 120 days of enrollment. Additionally, Participating Physician Groups PCPs shall make reasonable attempts to contact new members for scheduling an IHA.

Finding: The Plan did not ensure the completion of an IHA for new members within 120 days of enrollment.

Plan policy QI-047 stated Plan providers must ensure the completion of an IHA for each new member within 120 calendar days of enrollment. Additionally, the PCP shall make reasonable attempts to contact a member and schedule an IHA and shall document all attempts made in the member's medical record. However, the Plan did not ensure completion of an IHA for new members within the required time frame.

The verification study revealed that out of 32 requested medical records, 18 new members did not have a complete IHA within 120 days of enrollment.

During the interview, the Plan stated that IHA reports are generated for new members who are due, overdue, or approaching the 120-day IHA completion deadline. These reports are uploaded monthly to the Plan's provider portal for providers to conduct outreach to new members for IHA completion. Although, the Plan can identify members who have not completed an IHA, the Plan did not adhere to the policy and procedure and did not ensure the providers completed an IHA for new members within 120 days.

This is a repeat of the prior year finding - 2.1.1 Initial Health Assessment

If an IHA is not completed within the required timeline, new member's health needs may not be identified and addressed, increasing the risk of injury, and undetected disease, or disorder.

Recommendation: Implement policies and procedures to ensure the completion of IHAs within the required timeframe for new members.

2.1.2 Anticipatory Guidance for Lead Exposure

The Plan is required to comply with all existing final Policy Letters and APLs issued by DHCS. *(Contract, Exhibit E, Attachment 2 (1)(D))*

The Plan must ensure network providers provide oral or written anticipatory guidance to the parents or guardians of a child member that, at a minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age. This anticipatory guidance must be provided to the parent or guardian at each Periodic Health Assessment (PHA), starting at 6months of age and continuing until 72months of age. *(APL 20-016, Blood Lead Screening of Young Children)*

Every health care provider who performs a PHA of a child shall provide written or oral anticipatory guidance to a parent or guardian of the child, including at a minimum, the information that children can be harmed by exposure to lead.

The anticipatory guidance shall be performed at each PHA, starting at 6 months of age, and continuing until 72 months of age. *(CCR, Title 17, section 37100 (a)(1))*Plan policy, *QI-048 Quality Improvement* (effective 11/30/2023*),* stated the Plan will ensure through ongoing monitoring processes network providers provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child that, at a minimum, includes

information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age. This anticipatory guidance must be provided to the parent or guardian at each PHA, starting at 6months of age and continuing until 72 months of age.

Finding: The Plan did not ensure anticipatory guidance was provided to the parents or guardians of age-appropriate members.

Plan policy QI-048 stated the Plan will ensure network providers provide oral or written anticipatory guidance to the parents or guardians of child members starting at 6 months of age to 72 months of age. However, the Plan did not ensure the provision of verbal or written lead poisoning anticipatory guidance was provided to parents or guardians of age-appropriate members.

The verification study revealed that 13 out of 26 members did not have documentation that oral or written anticipatory guidance was provided to parents or guardians of child members.

During the interview, the Plan acknowledged using the IHA audit tool checklist for medical record review to monitor BLS and to ensure that the provision of verbal or written anticipatory guidance was provided to parents and guardians. However, the Plan did not ensure anticipatory guidance on lead levels was provided to parents or guardians by network providers.

This is a repeat of the prior year finding - 2.1.2 Anticipatory Guidance for Lead Exposure

If lead poisoning anticipatory guidance is not given to parents or guardians in a timely manner, potential preventative measures are delayed and/or missed, which may result in unnecessary exposure to lead or continued harmful contact.

Recommendation: Implement procedures to ensure parents or guardians of age-appropriate children receive oral or written anticipatory guidance on the harm caused by lead exposure to children.

2.1.3 Blood Lead Screening Tests

The Plan is required to comply with all existing final Policy Letters and APLs issued by DHCS. *(Contract, Exhibit E, Attachment 2 (1)(D))*

The Plan shall cover and ensure the provision of a BLS test to members at ages one and two. The Plan shall document and appropriately follow up on BLS test results, make

reasonable attempts to ensure the BLS test is provided, and shall document attempts to provide the test in the Member's Medical Record (MMR). Documentation shall also be entered into the MMR to indicate test results, or voluntary refusal of these services. *(Contract, Exhibit A, Attachment 10 (5)(D))*

The Plan must ensure that network providers order or perform BLS tests on all child members at 12 and 24 months of age, or when the network provider performing a PHA becomes aware that a child member 12 months to 24 months of age or a child member 24 to 72 months of age has no documented evidence of having taken a BLS test. The Plan must also ensure that the network provider documents the reasons for not performing the BLS test in the child member's medical record. *(APL 20-016, Blood Lead Screening of Young Children)*

Plan policy, *QI-048 Quality Improvement* (effective 11/30/2023), stated the Plan will ensure the network providers order or perform BLS tests on all child members at 12 months and at 24 months of age, and when the network provider becomes aware the child who is 12 to 72 months of age has no documented evidence of a BLS test taken.

Finding: The Plan did not ensure the provision of BLS tests to child members at ages one and two and did not document the reason for not performing a BLS test in the child's medical record.

Plan policy QI-048 stated that Plan providers are required to perform BLS testing on all children at 12 months and 24 months of age. However, the Plan did not ensure the provision of BLS tests to age-appropriate members.

The verification study revealed 14 out of 20 members did not have documentation of BLS tests, or the reason for not performing the BLS tests, in the child member's medical record.

During the interview, the Plan stated that on a monthly basis, a list of children who have not received a BLS test is uploaded to the provider portal to notify PCPs of the missing BLS tests.

Although, the Plan was able to identify child members that did not have a BLS test, the Plan did not ensure these tests were performed or that there was a documented reason in the MMR indicating why the BLS tests were not performed.

This is a repeat of the prior year finding - 2.1.3 Blood Lead Screening Tests

If age-appropriate BLS tests are not provided in a timely manner, at-risk children may not be identified and treated, which may result in lead poisoning that can cause adverse learning and behavioral problems.

Recommendation: Revise and implement policies and procedures to ensure the provision of BLS tests to child members at ages one and two are performed or the reason for not performing a BLS test is documented in the MMR.

COMPLIANCE AUDIT FINDINGS

Category 3 – Access and Availability of Care

3.8 Non-Emergency Medical Transportation / Non-Medical Transportation

3.8.1 Physician Certification Statement Forms

The Plan is required to comply with all existing final Policy Letters and APLs issued by DHCS. *(Contract, Exhibit E, Attachment 2 (1)(D))*

The member must have an approved PCS form authorizing NEMT services by the provider.

Additionally, the Plan is required to ensure a copy of the PCS form is on file for all members receiving NEMT services and that all fields are filled out by the provider. The PCS form is used to determine the appropriate level of service for members. The Plan can provide telephone authorization for NEMT requests when a member requires a Plan-covered medically necessary service of urgent nature, and a PCS form could not have reasonably been submitted beforehand. The member's provider must submit a PCS form post-service for the telephone authorization to be valid. *(APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expense)*

Plan policy, *MMUM-060 Coordinating Non-Emergency Medical Transportation & Non-Medical Transportation* (effective 07/18/2023), stated that NEMT services are subject to PA. Members can request a PCS Form from their treating physician by telephone, electronically, or in person. The Plan accepts telephonic authorization when a member requires to be transferred urgently and the PCS form could not have been submitted beforehand. The Provider is responsible for submitting the completed PCS form post-service for the telephone authorization to be valid. The Plan also conducts an internal audit monthly to ensure PCS forms are completed and submitted prior to services. The Plan will conduct outreach to providers who have not submitted a complete PCS form.

Finding: The Plan did not ensure a PCS form was on file for all members receiving NEMT services.

Although, Plan policy MMUM-060 stated the Plan would conduct outreach to providers when attempting to obtain a completed PCS form, the Plan did not follow the policy.

The verification study revealed that 6 of 21 NEMT trips did not have a PCS form on file for the member who received service. The verification study also showed that the Plan's transportation broker Call the Car attempted to call members directly to obtain a completed PCS form as opposed to the provider of record; no attempts were made to the requesting providers. As a result, the Plan did not obtain the required PCS forms post-service for urgent NEMT services.

During the interview, the Plan stated that the requests for urgent transportation services were escalated to Call the Car and the requesting provider was to submit the PCS form post-service. However, the Plan was unable to provide a copy of the PCS forms post-service.

Without obtaining PCS forms for NEMT trips, the Plan is unable to determine the appropriate level of service, which could subject members to an inappropriate mode of transportation that may result in unsafe conditions.

Recommendation: Revise and implement policies and procedures to ensure a PCS form is on file for all members receiving NEMT services.

COMPLIANCE AUDIT FINDINGS

Category 4 – Member's Rights

4.1 Grievance System

4.1.1 Discrimination Grievances

The Plan shall process a grievance for discrimination as required by federal and state nondiscrimination law stated in CFR, Title 45, section 84.7, CFR, Title 45, section 92.7, CFR, Title 34, section 106.8, CFR, Title 28, section 35.107, and W&I Code section 14029.91(e)(4). Plan shall designate a Discrimination Grievance Coordinator (DGC) responsible for ensuring compliance with federal and state nondiscrimination requirements and investigating discrimination grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law. Within ten calendar days of mailing a discrimination grievance resolution letter, the Plan shall submit the information regarding the discrimination grievance to the DHCS OCR. *(Contract, Amendment 30, Exhibit A, Attachment 14(9))*

The Plan must adopt grievance procedures that provide for the prompt and equitable resolution of discrimination grievances. The Plan must ensure that all discrimination grievances are investigated by the Plan's designated DGC. *(APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services)*

Plan policy, *AG-008 Grievance Process for* Members (effective 01/05/2024), stated the Plan has designated a DGC who will be responsible for investigating and processing any Americans with Disabilities Act, section 504, section 1557, and/or Government Code section 11135 grievances received by the Plan. Within ten calendar days of mailing a discrimination grievance resolution letter, the Plan will submit information regarding the discrimination grievance to the DHCS OCR, as specified in APL 21-004.

Finding: The Plan did not investigate, resolve, and submit discrimination grievances to DHCS OCR.

Although, Plan policy AG-008 stated the Plan has designated a DGC who is responsible for investigating and processing discrimination grievances, the Plan did not implement the policy.

The verification study revealed that out of 31 grievances cases, the four reviewed for discrimination were not investigated and submitted by the Plan to DHCS OCR.

During the interview, the Plan acknowledged not reporting the discrimination grievances to DHCS OCR. Additionally, the Plan stated that the Compliance Manager responsible for submitting discrimination cases was no longer employed with the Plan and that the appropriate shift in responsibilities was not completed. In a written response, the Plan confirmed there was no investigation conducted by a DGC.

When discrimination grievances are not processed and investigated by the Plan's DGC, member grievances may not be addressed and resolved appropriately which may lead to poor health outcomes. If the Plan does not submit the discrimination grievance information to the DHCS OCR, it may potentially affect the DHCS ability to take appropriate action in response to the members' grievances.

Recommendation: Implement policies and procedures to ensure that discrimination grievances are investigated, resolved, and reported by the Plan's designated DGC to the DHCS OCR.

4.1.2 Medical Director Participation in Quality-of-Care Grievances

The Plan shall implement and maintain procedures as described below for grievances and the expedited review of grievances required under CFR, Title 42, sections 438.402, 438.406, and 438.408; CCR, Title 28, sections 1300.68 and 1300.68.01, and CCR, Title 22, section 53858. The Plan will ensure the participation of individuals with authority to require corrective action. Grievances related to medical QOC issues shall be referred to the Plan's MD. *(Contract, Exhibit A, Attachment 14(2) and (2)(D))*

All grievances related to medical QOC issues must be immediately submitted to the Plan's MD for action. The Plan must ensure the person making the final decision for the proposed resolution of a grievance is a health care professional with clinical expertise in treating a member's condition or disease on any grievance involving clinical issues. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Plan policy, *AG-001 Appeal and Grievances Oversight and* Reporting (effective 05/31/2023), stated the Plan will ensure the participation of individuals with authority to require corrective action when QOC issues are involved.

The appeals and grievances are screened for medical QOC issues and immediately submitted to the Plan's MD for action. All identified potential QOC cases are referred

to the Quality Improvement (QI) Department for evaluation, investigation, and resolution. If the case meets Potential Quality of Care Issue (PQI) criteria, system edits will determine if clinical review or escalation to an MD is required.

Finding: The Plan did not ensure that QOC grievances were immediately submitted to the Plan's MD for action.

Although, Plan policy AG-001 stated that grievances are screened for medical QOC issues and immediately submitted to the Plan's MD for action, the Plan did not implement the policy. As outlined in the Plan's policy AG-001, all identified medical QOC grievances were forwarded to the QI Department for evaluation, investigation, and resolution.

The verification study revealed that 21 out of 21 QOC grievances were not reviewed by an MD. The Plan's process was to refer QOC grievances to the QI Department for PQI review. This process does not ensure that QOC grievances are immediately referred to the MD for action.

During the interview, the Plan acknowledged that all QOC grievances were not immediately submitted to an MD for action. Therefore, the Plan's process was ineffective in ensuring the immediate submittal of all QOC grievance to an MD for review as required by the Contract.

This is a repeat of the prior year finding - 4.1.2 Quality of Care Grievances

Failure to adhere to contract and legal requirements for QOC grievances may result in delays in action and in the involvement of the MD in the grievance process. Substandard or poor-quality medical care by providers may go unnoticed, inadequately investigated, or unresolved, potentially leading to medical harm to members.

Recommendation: Develop and implement policies and procedures to ensure all QOC grievances are immediately submitted to the MD for action and that QOC grievances comply with all grievance requirements.

4.1.3 Quality of Care Medical Director Resolution

The Plan shall maintain a full-time physician as MD pursuant to CCR, Title 22, section 53857 whose responsibilities shall include resolving grievances related to medical QOC. *(Contract, Exhibit A, Attachment 1(6)(E))*

The Plan shall ensure the person making the final decision for the proposed resolution of grievances and appeals have clinical expertise in treating a member's condition or

disease if deciding on any grievance or appeal involving clinical issues. *(Contract, Exhibit A, Attachment 14(1)(D))*

The Plan is required to ensure the immediate submittal of all medical QOC grievances to the MD for action. *(CCR, Title 22, section 53858(e)(2))*

The grievance system shall be established in writing, and provide for procedures that will receive, review, and resolve grievances. "Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance. *(CCR, Title 28, sections 1300.68(a) and 1300.68 (a)(4))*

Plan policy, *AG-001 Appeal and Grievances Oversight and Reporting* (effective 05/31/2023), stated the Plan will ensure the participation of individuals with authority to require corrective action when QOC issues are involved. The A&Gs are screened for medical QOC issues and immediately submitted to Plan's MD for action.

Finding: The Plan's MD did not resolve QOC grievances.

Although, Plan policy AG-001 stated grievances are screened for medical QOC issues and submitted to the Plan's MD for action, the Plan did not follow the policy and procedure to submit all QOC grievances to the MD for resolution. Instead, QOC cases were investigated and closed by a grievance specialist without an MD's resolution.

The verification study revealed 25 of 25 QOC grievances were not resolved by an MD. The Plan stated that QOC grievances were investigated and closed by a grievance specialist without the MD's resolution.

During the interview, the Plan acknowledged that all QOC grievances were not resolved by the MD and that a grievance specialist would investigate and resolve the member's QOC grievance.

Without an MD's resolution of QOC grievances, members' complaints about provider QOC do not reach a final decision by a person with clinical expertise and the ability to require corrective action. Therefore, subpar care may continue to be unaddressed, which may lead to member harm and delays in members receiving high quality care.

Recommendation: Revise and implement policies and procedures to ensure QOC grievances are resolved by an MD in the Grievance Department.

4.1.4 Clear and Concise Grievance Resolution Letters

The Plan is required to develop, implement, and maintain a Member Grievance System

in accordance with CCR, Title 28, sections 1300.68, and 1300.68.01 and CCR, Title 22, section 53858. *(Contract, Exhibit A, Attachment 14 (1))*

The Plan shall ensure that all member information is provided to members at a sixth grade reading level or as determined appropriate through the Plan's Group Needs Assessment and approved by DHCS. Member information shall ensure members' understanding of the Plan's processes and the member's ability to make informed health decisions. *(Contract, Exhibit A, Attachment 13 (4)(C))*

The Plan is required to establish and maintain written procedures for the submittal, processing, and resolution of all member grievances and complaints. The Plan's grievance procedure shall at minimum provide for a description of the action taken by the Plan or provider to investigate and resolve the grievance and the proposed resolution by the Plan or provider. *(CCR, Title 28, section 53858(a))*

The Plan is required to provide subscribers and members with written responses to grievances, with a clear and concise explanation of the reason for the Plan's response. The Plan's response shall describe the criteria used and clinical reasons for the decision, including all criteria and clinical reasons related to medical necessity. *(H&S Code section 1368(a)(5))*

The Plan's written resolution letter shall contain a clear and concise explanation of the Plan's decision. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Plan policy, *AG-008 Grievance Process for Members* (effective 01/05/2024), stated following a full investigation of a member's grievance, the Plan sends a written resolution letter to the member. The written resolution will contain a clear and concise explanation of the Grievance Department's decision. The notification will be in plain language and will not contain any abbreviations or acronyms that are not defined or health procedure codes that are not explained.

Finding: The Plan did not send members grievance resolution letters with a clear and concise explanation of the Plan's decision.

Although, Plan policy AG-008 stated that the Grievance Department's decision must contain a clear and concise explanation of the written resolution, the Plan did not send members resolution letters with a clear and concise explanation of the decision.

The verification study of 56 grievances revealed 30 letters did not contain a clear and concise explanation of the Grievance Department's decision. Although, the letters

contained the details of the grievance investigation, the letters did not inform members of the Plan's conclusion.

A breakdown of the letters is as follows:

- Seven Quality Of Services Resolution Letters did not contain a clear and concise explanation of the Plan's decision.
- Four Discrimination Resolution Letters did not contain a clear and concise explanation of the Plan's decision.
- Nineteen QOC Resolution Letters did not contain a clear and concise explanation of the Plan's decision.

In addition, the letters were not written at a sixth-grade reading level. Excerpts from the resolution letters include:

- She had nasal hyperemia with grayish thick nasal discharge, clear long and soft, non-tender abdomen.
- Their assessment is rhino sinusitis.
- They prescribed her ibuprofen 1½ tsp q 6 hours prn.
- According to the plan of treatment received: 80 hours per month of code H2019 to cover six-month period of service, 4 hours per month of code S5111 HC (MA/MS) to cover six-month period of services.

During the interview, the Plan stated the Grievance Coordinator's process is to investigate the member's grievance and include a summary as the Plan's final decision on the resolution letter.

This is a repeat of the prior year finding - 4.1.4 Grievance Resolution Letters.

Lack of a clear decision in the resolution letter could result in unnecessary delay or denial in the delivery of medically necessary services for members and may lead to member harm.

Recommendation: Develop and implement policies and procedures to ensure that grievance resolution letters include a clear and concise explanation of the Plan's decisions and are written at a sixth-grade reading level.

4.1.5 Written Consent for Grievances

A member, or a provider, or an authorized representative acting on behalf of a member and with the member's written consent, may file a grievance with the Plan either orally or in writing. *(Contract Exhibit A, Attachment 14 (1)(A))*

If state law permits and with the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance on behalf of an enrollee. *(CFR, Title 42, section 438.402(c)(1)(ii))*

A grievance may be filed either verbally or in writing by a member, a provider acting on behalf of the member, or an authorized representative. *(APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights")*

Plan policy, *AG-008 Grievance Process for Members* (effective 01/05/2024), stated that to be considered a representative of the member, written documentation must be received by the Plan. If the member has requested that someone other than themselves act on their behalf, a valid AOR form is required. The A&G Department will make at least three attempts to contact the member. Each attempt will be documented in the Plan's system. If the Plan does not receive the completed or valid AOR form or its equivalent within 30 calendar days, the case will be dismissed.

Finding: The Plan did not ensure that members' written consent was obtained for authorized representation when a grievance was filed on a member's behalf.

Plan policy AG-008 stated to be considered a representative of the member, written documentation must be received and an AOR form is required. However, the Plan did not obtain members' written consent authorizing representation when a grievance was filed on the members' behalf.

The verification study revealed the Plan processed 4 out of 25 grievances on behalf of the member without obtaining the member's written consent authorizing representation.

During the interview, the Plan stated that if a member's AOR is not on file, several attempts are made to inform members that the Plan cannot proceed and process their grievance without their verbal or written consent. However, the verification study showed that grievances were processed without an AOR on file for members.

This is a repeat of the prior year finding - 4.1.5 Written Consent for Grievances

When the Plan does not obtain a member's written consent prior to the filing of a grievance on their behalf, a member's personal health information may be compromised, and unauthorized decisions may be made concerning their health care.

Recommendation: Implement procedures to ensure the Plan obtains a member's written consent for authorized representation prior to a representative filing a grievance on behalf of the member.

COMPLIANCE AUDIT FINDINGS

Category 5 – Quality Management

5.3 Provider Qualifications

5.3.1 Provider Training

The Plan is required to ensure that all network 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. The Plan is required to conduct training for all network providers within ten working days after the Plan places a newly contracted network provider on active status. *(Contract, Exhibit A, Attachment 7 (5))*

Plan policy, *PNM EST-024 Provider Network Training* (effective 12/12/2018), stated all new providers are required to complete new provider onboarding training within ten business days of the effective date. Additionally, the Contract and Relationship Management Unit will administer the new provider onboarding training to directly contracted providers within ten business days of the active date.

Finding: The Plan did not train newly contracted providers within ten working days after being placed on active status.

Although, Plan policy PNM EST-024 stated that all new providers are required to complete new provider onboarding training within ten business days of the active date, the Plan did not ensure newly active providers were trained within ten days of becoming active with the Plan.

A verification study of the fourth quarter of 2023 revealed the Plan did not conduct training for 20 newly contracted network providers within ten working days after being placed on active status.

During the interview, the Plan stated that the data universe submitted did not reflect the actual active date for newly contracted providers and that a new universe would be provided. The original universe disclosed that 13 out of 30 newly contracted providers did not receive training within ten working days of becoming active. The updated list reflected in the verification study above was for the fourth quarter of 2023, which revealed that 20 providers did not receive training within the required

timeframe. Furthermore, the Plan did not follow up on providers that did not attend scheduled trainings.

This is a repeat of the prior year finding – 5.3.1 Provider Training

Without providing timely training, the Plan cannot ensure providers operate in full compliance with Medi-Cal program requirements. In addition, members might receive misinformation regarding their rights, available resources, and provider's responsibilities.

Recommendation: Revise and implement policies and procedures to ensure newly contracted providers receive training within the required timeframes.

COMPLIANCE AUDIT FINDINGS

Category 6 – Administrative and Organizational Capacity

6.2 Fraud and Abuse

6.2.1 Notification of Suspended and Ineligible Providers

The Plan is required to notify the PIU within ten working days of removing a suspended, excluded, or terminated provider from the provider network, and confirm that the provider is no longer receiving payments in connection with the Medicaid program. A removed, suspended, excluded, or terminated provider report can be sent to DHCS by email to PIUCASES@DHCS.ca.gov. *(Contract, Exhibit E, Attachment 2 (26)(B)(8))*

As part of the Plan's monitoring and oversight responsibilities, the Plan is required to review exclusionary databases on a regular basis, and at least monthly, take appropriate action in connection with the exclusion as set forth in APL 21-003. Upon discovery that a network provider/subcontractor has been excluded or suspended from the Medi-Cal program, the Plan must report to DHCS program integrity information related to fraud, waste, and abuse allegations, including any contract terminations, as described in the Plan's contract with DHCS, and as further required by DHCS. *(APL 21-003, Medi-Cal Network Provider and Subcontractor Terminations)*

Plan policy, *PNMCRD-010 Ongoing Monitoring* (effective 01/25/2024), stated the credentialing staff conducts monitoring of published data by regulatory agencies on a monthly basis. Enterprise Performance Optimization (EPO) will conduct oversight and monitoring of credentialing activities to ensure the Credentialing Department's compliance. Any practitioners identified as sanctioned, debarred, suspended, or excluded from payment are reported to the EPO Department and the Special Investigation Unit (SIU) for further action.

Plan's desktop procedure, *PNMCRD PR-010 Monitoring of Exclusion, Suspensions, and Debarred Practitioners and Providers* (effective 01/25/2024), stated all out of network excluded/suspended practitioners/providers will be included on a "Daily Claims Edit" report and a copy of the report will be submitted to the Plan's Payment Integrity Unit and SIU monthly.

Finding: The Plan did not notify the PIU within ten working days of removing a suspended, excluded, or terminated provider from the provider network.

A review of the Plan's monitoring and oversight procedures for terminated and/or suspended and ineligible providers revealed that the Plan's policy PNMCRD-010 and desktop procedure PNMCRD PR-010 did not include a process to ensure the PIU was notified within ten working days of removing a suspended and ineligible provider from the provider network. The Plan's monitoring and tracking reports identified providers as being on the Medi-Cal Suspended and Ineligible Provider list.

During the interview, the Plan stated that the providers were either terminated and removed from the provider network and/or flagged to prevent future payments. However, the Plan was unable to provide any documentation to confirm that the PIU was notified as required by the Contract.

When the Plan does not notify the PIU of the removal and termination of suspended and ineligible providers from the provider network, DHCS will not be able to evaluate the overall member impact due to the termination of the provider or subcontractor.

Recommendation: Develop and implement policies and procedures to ensure notification to the PIU within ten working days of removing a suspended, excluded, or terminated provider from the provider network.

6.3 Encounter Data

6.3.1 Accuracy of Claims and Encounter Data for Directed Supplemental Physician Payments

Plan shall implement policies and procedures for ensuring complete, accurate, reasonable, and timely submission of encounter data to DHCS for all items and services furnished to a Member under this contract, whether directly or through subcontracts or other arrangements. *(Contract, Exhibit A, Attachment 3(2)(B))*

Plan shall require subcontractors and noncontracting providers to submit claims and encounter data to Plan to meet its administrative function and the requirements set forth in this section. The Plan shall have in place mechanisms, including edit and reporting systems sufficient to assure encounter data is complete, accurate, reasonable, and timely prior to submission to DHCS. *(Contract, Exhibit A Attachment 3(2)(C))*

Eligible rendering providers can provide and bill Current Procedural Terminology (CPT) codes. The Plan is responsible for ensuring qualifying services reported using the specified CPT codes are appropriate for the services being provided and reported to DHCS in the Encounter Data. *(APL 19-015, Proposition 56 Directed Payments for Physician Services)*

Plan policy, *FC-004, Proposition 56 Directed Payments Program Policy* (effective 8/28/23), stated the Plan must ensure that their subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. Plan is responsible for determining that the encounter data reported to DHCS is appropriate for the services provided. Plan is responsible for ensuring qualifying physician services using the specified CPT codes are appropriate for the service provided and are submitted to DHCS in encounter data that is complete, accurate, reasonable, and timely.

Finding: The Plan did not ensure their subcontractors and network providers submitted accurate encounter data for services furnished to a member for directed supplemental physician payments.

Plan policy FC-004 stated that the Plan is responsible for ensuring the encounter data reported to DHCS is appropriate and accurate for the services provided. However, a verification study of 15 medical records from the Plan's Proposition 56 directed payment encounters disclosed that the data reported to DHCS was not accurate. Proposition 56 is a program that provides supplemental payments for certain eligible physician services delivered to Medi-Cal beneficiaries on or after July 1, 2017. An example of the inaccurate encounters is as follow:

- Eight records had billing codes that did not match the service rendered. Provider billed using the evaluation and management code 99213 for subsequent prenatal visits when Z1032 should have been used and provider billed using 99215 when Z1034 should have been used to bill for the service.
- Six medical records did not have the modifier to indicate that the services were rendered by a mid-level provider.
- Two medical records did not have the correct rendering physician number of the physician that provided the service.

During the onsite interview, the Plan stated their process is to pay providers for the Proposition 56 direct supplemental payments if the claim is for an eligible member, service code, and provider who is not listed on the S&I list. However, the Plan acknowledged that they do not have a method to ensure that the code billed is

accurate for the service rendered and for determining the eligibility of the rendering provider. As a result, inaccurate supplemental payments were paid to providers by the Plan.

When the Plan submits inaccurate encounter data to DHCS, it can lead to incorrect data collection and analysis. Without ensuring data accuracy, the risk of provider fraud, waste, and abuse is increased. Furthermore, when the rendering provider is not accurately identified, the Plan is unable to verify their eligibility status against the S&I list, which may expose members to potential harm from unauthorized providers.

Recommendation: Implement policies and procedures to ensure accurate submission of encounter data to DHCS for directed supplemental physician payments.

DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

RANCHO CUCAMONGA – SECTION

REPORT ON THE MEDICAL AUDIT OF LOCAL INITIATIVE HEALTH AUTHORITY FOR LOS ANGELES COUNTY DBA L.A. CARE HEALTH PLAN FISCAL YEAR 2023-24

Contract Number(s): 22-20466 and 23-30264

Contract Type: State Supported Services

Audit Period: February 1, 2023 —– January 31, 2024

Dates of Audit: June 10, 2024 —– June 21, 2024

Report Issued: January 16, 2025

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I. INTRODUCTION

This report presents the results of the audit of Local Initiative Health Authority for Los Angeles County dba L.A. Care Health Plan (Plan) compliance and implementation of the State Supported Services contract numbers 22-20466 and 23-30264 with the State of California. The State Supported Services Contracts cover abortion services with the Plan.

The audit covered the period of February 1, 2023, through January 31, 2024. The audit was conducted from June 10, 2024, through June 21, 2024, which consisted of a document review and verification study with the Plan administration and staff.

An Exit Conference with the Plan was held on December 18, 2024. No deficiencies were noted during the review of the State Supported Services Contracts.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Plan is required to provide, or arrange to provide, to eligible members the following State Supported Services: Current Procedural Terminology Codes 59840 through 59857 and Health Care Financing Administration Common Procedure Codes X1516, X1518, X7724, X7726 and Z0336. These codes are subject to change upon the Department of Health Care Services implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code sets provisions. *(State Supported Services Contract, Exhibit A)*

Plan policy, *CLM-029 Abortion Services* (effective 06/28/2022), stated that the Plan will cover an abortion as a physician service regardless of the gestational age of the fetus, as well as the medical services and supplies incidental or preliminary to an abortion. Additionally, for outpatient services, no medical justification or prior authorization is required.

The Plan's Member Handbook also provided information on abortion services. The Member handbook stated that if your Primary Care Physician, hospital, or other provider has a moral objection to providing you with an abortion, call Member Services. For minors, if you are under the age of 18, you can receive abortion services without a parent or guardian's permission.

A review of the Plan's claims processing reports revealed that the Plan appropriately processed, paid, or denied abortion service claims within the standard timeframes.

Based on the review of the Plan's documents, there were no deficiencies noted for the audit period.

Recommendation: None