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

REPORT ON THE MEDICAL AUDIT OF

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

2021

Contract Number: 04-36069

Audit Period: July 1, 2019
Through
June 30, 2021

Report Issued: February 3, 2022

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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 its Knox Keene license in April 1997.

The Plan provides Managed Care health services to Medi-Cal beneficiaries under the provision of the Welfare and Institutions Code, 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 it 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. In addition, to the Plan Partners model, the Plan began providing coverage directly to Medi-Cal members under its own line of business Medi-Cal Care Los Angeles (MCLA) in 2006. In its direct line of business, the Plan contracts with 41 Participating Physician Groups (PPGs) who receive a capitated payment for each member.

As of July 2021, the Plan’s total enrollment was approximately 2,427,870 members. The detailed enrollment by product lines are as follows: 2,260,777 Medi-Cal (Plan Partners, and MCLA), 18,800 Cal MediConnect, 97,088 L.A. Care Covered California, and 51,205 Homecare and Workers Health Care Plan.

II. EXECUTIVE SUMMARY

The audit report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period July 1, 2019 through June 30, 2021. The review was conducted from July 12, 2021 through July 23, 2021. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan 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 six categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Members' Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit report issued on November 8, 2019, for the audit period July 1, 2018 through June 30, 2019, identified deficiencies, which were addressed in a Corrective Action Plan (CAP). The CAP close out letter September 2, 2020 documented that DHCS closed all previous findings.

On July 19, 2021, Centers for Medicare and Medicaid Services (CMS), DHCS (Managed Care Operations Division (MCOD) and Managed Care Quality and Monitoring Division (MCQMD)) jointly issued a warning letter to the Plan related to sales and marketing activities for the Cal MediConnect line of business.

In addition, DHCS issued the following letter during the review period:

- On July 16, 2021, DHCS (MCOD and MCQMD) issued a noncompliance letter to the Plan for failing to process and resolve standard and expedited grievance and appeals resolution letters, as well as failing to process prior authorizations.

A summary of the findings by category follows:

Category 1 – Utilization Management (UM)

Category 1 includes procedures and requirements of the Plan's UM program, including prior authorization review, the appeal process, and delegation of UM.

The Plan is required to process and notify the requesting member of any decision to deny, approve, modify, or delay a prior authorization within the required timeframes. The Plan delayed processing and notifying members' prior authorization requests.

The Plan is required to send a member an appeal resolution notice within 30 calendar days. The Plan did not resolve and send Notice of Appeal Resolution (NAR) letters to members within the required timeframes for expedited and standard appeals.

The Plan and its delegates are required to comply with the UM requirements for prior authorization services. The Plan did not ensure that one of its delegated entities complied with UM requirements.

The Plan and its delegates are required to comply with the UM requirements for dental anesthesia. One of the delegates did not comply with UM requirements for dental anesthesia services to its members.

The Plan and its delegates are required to comply with delegate subcontractor ownership and control requirements. The Plan did not ensure one of the delegates complied with delegate subcontractor ownership and control disclosure requirements.

Category 2 – Case Management and Coordination of Care

Category 2 includes procedures and requirements for California Children Services (CCS) and Continuity of Care (COC).

The Plan is required to authorize Private Duty Nursing (PDN) services for CCS covered conditions. The CCS policy and procedures did not include procedures to authorize PDN services for CCS members.

The Plan is required to have a process and to notify the member 30 calendar days before the end of the COC period with the transitional process of the member's care to an in-network provider. The Plan did not inform members 30 calendar days before the end of the COC period about the transition process.

The Plan is required to approve or deny COC services based on criteria listed in All Plan Letter (APL) 18-008. The Plan applied incorrect criteria when denying or modifying COC services.

Category 3 – Access and Availability of Care

Category 3 includes procedures and requirements for Provider Directory and Access to Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services.

The Plan is required to distribute a Provider Directory that includes the provider name, provider number, address, and telephone number of each service location. The Plan's electronic and online Provider Directories contained inaccurate information.

The Plan is required to ensure its NEMT and NMT providers are enrolled in the Medi-Cal program. The Plan did not ensure NEMT and NMT providers were enrolled in the

Medi-Cal program.

Category 4 – Member's Rights

Category 4 includes procedures and requirements related to handling grievances.

The Plan is required to resolve and notify the member of the grievance resolution in writing within the required timeframe. The Plan did not resolve and send grievance resolution letters to members within the required timeframe.

The Plan is required to use the "Your Rights" Attachment containing correct information when sending notification letters to members. The Plan included incorrect State Fair Hearing information with grievance extension letters sent to members.

The Plan is required to establish and maintain a system of aging of grievances and appeals that are pending and unresolved for 30 calendar days or more. The Plan did not monitor and track grievance resolution letters when resolution was not completed or reached within 30 calendar days.

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 the grievance resolution letters with clear explanation of the Plan's decisions to members.

Category 5 – Quality Management

No findings noted for the audit period.

Category 6 – Administrative and Organizational Capacity

Category 6 includes procedures and requirements related to reporting of overpayments.

The Plan is required to comply with all existing final Policy Letters and APLs issued by DHCS. APL 17-003 requires the Plan to create an internal retention and documentation process for recovery of all overpayments and annually report its recovery of overpayments to DHCS. The Plan's policy and procedures were not updated to include contract and APL requirements.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The audit was conducted by the DHCS Medical Review Branch to ascertain that services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's Two-Plan Contract.

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 contract with DHCS, its policies for providing services, the procedures used to implement and execute the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 20 medical and pharmacy prior authorizations were reviewed for timely decision-making, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Appeals: 13 medical and pharmacy appeals were reviewed for appropriateness and timely decision-making, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Category 2 – Case Management and Coordination of Care

CCS: 20 CCS files and six CCS grievance files were reviewed for compliance.

COC: 21 medical records were reviewed to evaluate timeliness and appropriateness of COC request determination.

Category 3 – Access and Availability of Care

Provider Directory: 22 providers from the Provider Directories were reviewed for accuracy of information.

Emergency Services and Family Planning Claims: Seven emergency service claims and ten family planning claims were reviewed for appropriate and timely adjudication.

NEMT: 20 records were reviewed to confirm compliance with NEMT requirements.

NMT: 16 records were reviewed to confirm compliance with NMT requirements.

NEMT and NMT Grievances: Ten records were reviewed for response to complainant and submission to the appropriate level of review.

Category 4 – Member's Rights

Grievance Procedures: 84 grievances (13 quality of care, 71 quality of service, 24 exempt, and 26 expedited) were reviewed for timely resolutions, response to complainants, and appropriate level of review and medical decision-making. In addition, 111 call inquiry logs were reviewed for appropriate classification.

Category 5 – Quality Management

Potential Quality of Care issues: 17 cases were reviewed for reporting, investigation, and remediation.

New Provider Training: 27 contracted providers were reviewed for timely Medi-Cal Managed Care program training.

Category 6 – Administrative and Organizational Capacity

Fraud, Waste, and Abuse Reporting: Two cases were reviewed for proper reporting of all suspected fraud and/or abuse to DHCS within the required time frames.

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

CATEGORY 1 - UTILIZATION MANAGEMENT

1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Prior Authorizations Processing and Notification

The Plan is required to notify members of a decision to deny, defer, or modify requests for prior authorization. The Plan is required to provide Notice of Action (NOA) to members and/or their authorized representative, regarding any denial, deferral, or modification of a request for approval to provide a health care services. (*Contract, Exhibit A, Attachment 13 (8))*

The Plan is required to ensure that prior authorization, concurrent review, and retrospective review procedures meet the following minimum requirements: Notification to members regarding denied, deferred, or modified referrals is made as specified in Exhibit A attachment 13. (*Contract, Exhibit A, Attachment 5 (2(F)))*

In addition, the Plan is required to adhere to the following time frames for Medical authorization: D. Concurrent review of authorization for treatment within five working days or less, consistent with urgency of the Member's medical condition, E. Retrospective review within 30 calendar days based on Health and Safety Code section 1367.01, G. Routine authorizations within five working days from receipt of the information, H. Expedited Authorizations within 72 hours after the receipt of the request. *(Contract, Exhibit A, Attachment 5 (3))*

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 members 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 member'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-002: Referral Request Management* (Reviewed: 1/28/2021) describes that the Plan maintains current processes and

guidelines for reviewing requests for authorization and making UM determinations for health care services requiring authorization. The Plan's policy specifies regulatory required timeliness standards for urgent and routine requests during the UM review decision making and subsequent notification time frames of the decision to both the member and provider.

Finding: The Plan delayed processing and notifying of prior authorization requests regarding member clinical and related health care service needs, including urgent and routine outpatient prior authorization, inpatient concurrent (urgent and routine) prior authorization, and retrospective requests.

Additionally, one of the Plan's out-of-network inpatient providers reported to DHCS that the Plan was non-responsive for up to 55 days regarding multiple inpatient, pre-service, and retrospective authorizations.

The Plan provided the following information:

- 4,544 Medi-Cal inpatient authorizations (including concurrent) requests were not processed.
- 3,778 Medi-Cal pre-service and retrospective authorization requests were not processed.

During the interview, the Plan disclosed that it had become aware of these issues in late March 2021.

The Plan stated that the primary root causes for these deficiencies were related to the following: the Plan's conversion to a new software system for the UM function beginning early April 2021, staff training issues, glitches in the new system which required improvement and modification for optimal efficiency, higher than normal inpatient requests as a result of COVID-19 pandemic in the community, high-volume "non-actionable" authorization requests including multiple duplicate requests, requests that do not actually require authorization, and unexpectedly high reduction in staff due to leave, leaves of absence, and bereavement due to COVID-19 related issues.

If the Plan does not ensure proper functioning of the systems and processes related to service authorization requests this may severely and adversely impact the ability of members to obtain medically necessary services.

Recommendation: Implement and monitor the existing process to ensure service authorization requests are processed within the required timeframes.

1.3	PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Appeal Resolution Letters

The Plan is required to send a member appeal resolution notice within 30 calendar days. *(Contract, Exhibit A, Attachment 14 (4(B)(4)))*

The Plan is required to resolve standard appeals in 30 calendar days and 72 hours for expedited appeals and to send written resolutions to the members. *(APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments (Issued: 05/09/2017))*

The Plan's *Policy and Procedure AG-007: Appeals Process for Members* (Reviewed: 01/09/2019), describes the Plan's maintenance of a full and fair appeals process for concurrent, pre-and post-service appeals filed by members or authorized representative based on medical necessity. The Plan resolves expedited appeals within 72 hours and standard routine concurrent, pre- and post-service appeals are resolved within 30 calendar days from the date of filing.

The Plan's *Policy and Procedure AG-001: Appeals & Grievance Oversight* (Reviewed: 09/14/2018), describes the general provisions and oversight for the Grievance and Appeal (G&A) system in a timely manner.

Finding: The Plan did not resolve and send NAR letters to members within the required timeframes.

A verification study of 13 appeals demonstrated that the Plan did not send NAR letters in two cases.

The Plan acknowledged non-compliance with NAR. The Plan conducted a data validation review confirming that NAR letters were not sent to members as follows:

- 2018- 2019, no NAR letters were sent for 406 out of a total of 4,792 appeals.
- 2020-February 28, 2021, no NAR letters were sent for 1,020 out of a total of 5,617 appeals.

During the interview, the Plan stated that the root cause involved multiple factors: turnover of management and line staff, lack of monitoring appeals by senior management, escalation in G&A case volume per staff member, moving administrative functions from an office to home environment, and the COVID-19 pandemic. In addition, the Plan stated that their existing system did not alert the Plan that a NAR letter was not

sent to members.

Failure to send members NAR letter could negatively impact the appropriate care, service provision, and members' rights.

Recommendation: Develop and implement policies and procedures to ensure the Plan resolves and sends NAR letters to members within required timeframes.

1.5 DELEGATION OF UTILIZATION MANAGEMENT

1.5.1 Delegation of Utilization Management Oversight of Prior Authorization Process

The Plan is accountable for all quality improvement functions and responsibilities (e.g. UM, Credentialing, and Site Review) that are delegated to subcontractors. If the Plan delegates UM activities, it is required to comply with requirements for Delegation of Quality Improvement Activities. *(Contract, Exhibit A, Attachments 4 (6) and Attachment 5 (5))*

The Plan and any entity with which it contracts for services that include utilization review or UM functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with Health and Safety Code, section 1367.01. In addition, the Plan is required to have written policies and procedures establishing the process by which it 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. (*Health and Safety Code, section 1367.01 (a) and (b))*

The Plan is required to ensure that its prior authorization, concurrent review, and retrospective review procedures meet the following requirements set forth in Exhibit A, Attachment 5: 1. There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated, and 2. Reasons for decisions are clearly documented. *(Contract, Exhibit A, Attachment 5 (2D) and (2E))*

The Plan is required to notify members of a decision to deny, defer, or modify requests for prior authorization, in accordance with Title 42 Code of Federal Regulations (CFR) 438.210(c) and California Code of Regulations (CCR), Title 22, sections 51014.1 and 53894 by providing a NOA to members and/or their authorized representative. *(Contract, Exhibit A, Attachment 13 (8))*

The Plan is required to give members timely and adequate notice of an adverse benefit determination in writing consistent with the requirements of this section and section 438.10. (*Title 42 CFR, section 438.404(a))*

The Plan must conduct ongoing oversight to monitor the effectiveness of this process. The requirements shall only pertain to decisions based in whole or in part on medical necessity. Plans shall ensure that the NOA still provides a clear and concise explanation of the reasons for the decision. *(APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments (Issued: 05/09/2017)*

The Plans are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance including APL 17-004, APL 17-006, and APL 19-009.

Plan *Policy and Procedure CA-001: Clinical Assurance Oversight of Delegated Function* (Reviewed: 11/26/2018) states, "The Plan remains accountable for and has appropriate structures and mechanisms to oversee delegated activities. Delegated activities are reviewed on an annual basis according to specifications described in a mutually agreed upon delegation agreement. In addition, the Plan monitors delegation, oversight function and processes through established supervisory processes including but not limited to the UM Oversight Workgroup committee report and direction."

Finding: The Plan did not ensure that one of its delegated entities complied with UM and prior authorization requirements.

DHCS requested case files to conduct a verification study of the Plan's compliance related to the oversight of this delegate's prior authorization process; however, the Plan did not provide any case file documentation.

The Plan responded that prior authorization was not required for services provided within the delegated group's delivery system or in-network specialty care. The Plan explained that the delegated entity utilized an online electronic consultation system for review of medically indicated services including specialty referral, service authorization requests, and care coordination between a Primary Care Provider (PCP) and a Specialist. The tool optimizes the decision process regarding necessity for medical services. As an example the Plan indicated that tool use resulted in UM decisions to provide a direct face-to-face or telehealth specialty visit 75 percent of the time. Conversely, UM decisions with no face-to-face or telehealth specialty visit were deemed not medically necessary 25 percent of the time.

The Plan was not able to demonstrate that the system was in compliance with the requirements for written documentation related to medical necessity decisions regarding denials, modifications, or delays in service decisions during interviews and a demonstration by the delegated entity and Plan physicians. Furthermore, no NOA letters were generated related to adverse benefit determinations to members and providers, and no corresponding "Your Rights" attachments sent, informing a member that a medical service had been denied, deferred, or modified. Members were not informed of 1.The action that the Plan or its contractor has taken or intends to take, 2. The reason for the action (medical decision making), 3. The member's or provider's right to file an appeal, 4. The member's right to request a State Fair Hearing, 5. Procedures for exercising the member's rights to appeal or grieve, 6. Circumstances under which an expedited review is available and how to request it, 7. The member's right to have benefits continue pending the resolution of the appeal, and 8. How to request benefits continuation.

Another issue was also noted specifically regarding member rights. Information submitted by the delegated entity and the Plan revealed the existence of an additional appeal process at the delegate level outside of the one reserved to the Plan pursuant to the delegation agreement. The delegate's response indicated, "If the patient disagrees with the outcome of the PCP-specialist decision making, they have full appeal rights and the decision is taken for secondary review to the delegate Director of the electronic consultation system, who, if needed, involves the relevant specialist experts." The Plan included appeals related to the decisions made from the delegate's system in its appeal adjudication procedure.

Additionally, the Plan's UM delegation and related Quality Improvement oversight and monitoring processes did not include procedures to review the delegated entity's electronic consultation system. During the interviews, the Plan stated that the system was not part of their audit program or ongoing monitoring of the delegated entity's UM function.

If the Plan does not effectively oversee the compliance of UM systems and processes related to notification to members and providers this may adversely impact members and deprive them of information for obtaining necessary medical services and exercising their rights.

Recommendation: Revise and implement UM delegation oversight processes and procedures to ensure that the Plan and its delegated entity is compliant with all UM requirements.

1.5.2 Authorization for Dental Anesthesia

The Plan is accountable for all quality improvement functions and responsibilities (e.g. UM, Credentialing, and Site Review) that are delegated to subcontractors. If the Plan delegates UM activities, it is required to comply with requirements for Delegation of Quality Improvement Activities. *(Contract, Exhibit A, Attachments 4 (6) and Attachment 5 (5))*

The Plan must provide prior authorization for IV sedation and general anesthesia for dental services and must assist providers and beneficiaries with the prior authorization process as a form of care coordination to avoid situations where services are unduly delayed. The Plans are responsible to ensure that their subcontractors adhere to the policy. *(APL 15-012: Dental Services-Intravenous Sedation and General Anesthesia Coverage (issued: 08/21/2015))*

The Plan maintains the responsibility of ensuring that delegates are, and continue to be, in compliance with all applicable Medi-Cal, state and federal laws, and contractual requirements. (*APL 17-004: Subcontractual Relationships and Delegation (Issued: 04/18/20217))*

The Plan's *Policy and Procedure MMUM-058: Dental Screening, Referral and Services for Medi-Cal Members* (Reviewed: 12/2/2019) states, "the Plan is responsible to ensure that children and adults are referred to the Medi-Cal Denti-Cal Program for dental screening and treatment when treatment needs are identified". In addition, the Plan is required to follow DHCS modified policy for IV sedation and general anesthesia for dental procedures and to develop and publish the procedures for obtaining prior authorization to ensure that services for members are not unduly delayed.

The Plan's *Policy CA-001: Clinical Assurance Oversight of Delegated Function* (Reviewed: 11/26/2018), describes delegation oversight activities conducted by the Clinical Assurance Department for UM functions to monitor delegates according to the standards established by the Plan and contractual obligations. The Plan remains accountable for and has appropriate structures and mechanisms to oversee delegated activities. Delegated activities are reviewed on an annual basis according to specification described in a mutually agreed upon delegation agreement. The Plan monitors and oversees the delegate's performance of the delegated UM activities through ongoing UM reports, quarterly or continuous file reviews for denials, adverse determinations and Plan Partners appeals, bi-annual supplemental care coordination file reviews, and continuous monitoring of the delegate as needed.

Finding: The Plan and its delegate did not always provide dental anesthesia services to its members.

A verification study of one PPG/Independent Practice Association (IPA) delegates prior authorization for dental anesthesia revealed six cases with denial reason, “Carve Out” or “Not a Benefit.” Two cases were discussed with the Medical Director of the delegated entity, who confirmed that they were incorrectly administratively denied as “Carve Out”, and that the prior authorization adjudication decision incorrectly included dental anesthesia as “Carve Out” along with the dental services.

The Plan acknowledged that it did not analyze and oversee the provision of these specific services for quality improvement or require corrective action from delegated network groups. The Plan did not analyze and conduct specific oversight activities directly related to dental anesthesia.

If the Plan does not effectively oversee the process and procedures of its delegates, this may adversely impact medically necessary services received by members.

Recommendation: Develop and implement effective delegate oversight procedures to ensure that members receive medically necessary services.

1.5.3 Oversight of Network Delegate and Subcontractor Ownership and Control

The Plan may enter into subcontracts with other entities in order to fulfill the obligations of the Contract. The Plan is required to maintain policies and procedures, approved by DHCS, to ensure that subcontractors fully comply with all terms and conditions of the Contract. In addition, the Plan is required to evaluate the prospective subcontractor’s ability to perform the subcontracted services, shall oversee and remain responsible and accountable for any functions and responsibilities delegated and shall meet the subcontracted requirements as stated in Title 42 CFR 438.230(b)(1), (c)(1)(i)-(iii), (c)(2), (c)(3) and CCR, Title 22, sections 53250 and APL 17-004. In addition, subcontractor agrees to comply with all applicable requirements of the DHCS and Medi-Cal Managed Care program. *(Contract, Exhibit A, Attachment 6 (14))*

DHCS requires each subcontract submitted for DHCS approval shall contain at least the following: 3. Subcontractor’s agreement to maintain and make available to the DHCS, upon request, copies of all sub-subcontracts and to ensure that all subcontracts are in writing, 4. Subcontractor’s agreement to notify the DHCS in the event the agreement with the contractor is amended or terminated and specification that the subcontract shall be governed by and construed in accordance with all laws, regulations, and contractual

obligations incumbent upon the Plan. (*CCR, Title 22, section* 53250 (e)(3) and (4), and (c)(2))

The Plans are ultimately responsible for ensuring that their subcontractors and delegated entities comply with all applicable state and federal laws and regulations; contract requirements; reporting requirements; and other DHCS guidance. (*APL 17-004: Subcontractual Relationships and Delegation (Issued: 04/18/20217))*

The Plan is required to collect and review their subcontractors' ownership and control disclosure information. Subcontractors are required to provide written disclosure of information regarding subcontractors' ownership and control. The review of ownership and control disclosures applies to subcontractors contracting with the Plan. (*APL 17-004: Subcontractual Relationships and Delegation (Issued: 04/18/20217))*

The Plan's *Policy and Procedure CA-001: Clinical Assurance Oversight of Delegated Function* (Reviewed: 11/26/2018), describes the Plan's delegation oversight processes conducted by the Clinical Assurance Department for UM functions to monitor delegates according to the standards established by the Plan and contractual obligations. The Plan remains accountable for and has appropriate structures and mechanisms to oversee delegated activities. Delegated activities are reviewed on an annual basis according to specifications described in a mutually agreed upon delegation agreement. In addition, the Plan monitors delegation and oversight function and processes through established supervisory processes including but not limited to the UM Oversight Workgroup Committee report and direction.

The Delegation Agreement between the Plan and a delegated entity states that the delegated entity shall not assign the delegation agreement, or any interest herein or obligation hereunder, without the prior written consent of the Plan. PPG shall not subcontract the performance of all or any portion of the delegated activities contemplated hereby to any third party without the prior written consent of the Plan.

Finding: The Plan did not ensure one of the delegates complied with subcontractor ownership and control disclosure requirements.

A review of documents indicated that the Plan delegated the UM function to 45 out of 52 delegated entities (Preferred Provider Groups, IPA, and Plan Partners (PP). The audit team performed a focused review related to ownership and control for one of the delegated entities. The Plan was not able to provide supporting documentation related to a change in relationship between a delegated entity and its subcontractor.

During the interview with the selected delegated entity, the audit team was informed about a merger between the delegated parent company and one of its subcontractors Management Service Organization (MSO) in 2017. The Plan confirmed that they were fully aware of this relationship; however, they could not locate supporting documentation or amendments to the Contract regarding the delegated parent company and the subcontracted MSO or that they collected and reviewed relevant ownership and control disclosure information.

The deficiency is a result of lack of internal controls in the Plan's system of delegates' oversight. The Plan's Policy CA-001 does not comprehensively address additional delegated entity subcontracting relationships with a sub-subcontractor such as MSO, whether direct or indirect, through further and/or additional layers of contracting or delegation. Furthermore, the Plan did not ensure that the subcontractor complied with the delegation agreement related to ownership and notification.

Failure to ensure compliance with the requirements for Plan delegation oversight could adversely impact member's ability to obtain medically necessary services and care.

This is a repeat finding from prior audit finding **1.1.1 – Documentation of the Plan's Oversight of its Delegates and Subcontractors.**

Recommendation: Develop an effective process to monitor the delegates regarding ownership and control.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	CALIFORNIA CHILDREN'S SERVICES

2.1.1 Private Duty Nursing Services

The Plan's Contract states that once eligibility for the CCS program is established for a member, the Plan is required to provide all Medically Necessary Covered Services that are not authorized by CCS and shall ensure the coordination of services and joint case management between its PCP, the CCS specialty providers, and the local CCS program. If the local CCS program does not approve eligibility, the Plan remains responsible for the provision of all Medically Necessary Covered Services to the member. If the local CCS program denies authorization for any service, the Plan remains responsible for obtaining the service, if it is medically necessary, and paying for the service if it has been provided. *(Contract, Exhibit A, Attachment 11 (9(A)(5) and (6))*

The Plan is contractually obligated to provide case management services to members. If the Plan is the entity that approved the PDN services for an eligible member under the age of 21, the Plan is primarily responsible for providing case management to arrange for all approved PDN service hours. If another entity, such as CCS, has authorized PDN services and is primarily responsible for providing case management for those PDN services, the Plan must still provide case management as necessary, including, at the member's request, arranging for all approved PDN services. (*APL 20-012: Private Duty Nursing Case Management Responsibilities For Medi-Cal Eligible Members under The Age Of 21 (Issued: 05/15/2020))*

The Plan's *Policy and Procedure MMUM-069: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members under the Age of 21* (Reviewed: 05/10/2021), states the Plan will provide case management services as set forth in its Medi-Cal contract to all Plan enrolled Medi-Cal beneficiaries who are Early Periodic Screening, Diagnostic Treatment eligible and for whom Medi-Cal PDN services have been approved.

Finding: The existing CCS policy and procedure did not include procedure to authorize PDN services for CCS members.

During the interview the Plan informed the audit team that the Plan's Compliance Department is in-charge of informing the head of the CCS Department of new APL changes related to CCS services. The head of the CCS Department is responsible for

revising the policy and procedure and implementing the changes within the CCS Department. However, the Plan did not update its policy and procedure based on APL requirements.

Without an effective policy and procedure, PDN services will be impacted, delayed, and CCS members will not have access to medically necessary services.

Recommendation: Revise and implement policy and procedure to include authorization of PDN services for CCS members.

2.4	CONTINUITY OF CARE

2.4.1 Notification of End of the Continuity of Care Period

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

The Plan must notify the member 30 calendar days before the end of the COC period about the process that will occur to transition the member's care to an in-network provider at the end of the COC period. (*APL 18-008: Continuity of Care for Medi-Cal Members who Transition into Medi-Cal Managed* Care *(Revised: 07/10/2018))*

The Plan's *Policy and Procedure MM-UM-021: Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care* (Reviewed: 06/01/2016), states that the Plan must notify the member 30 calendar days before the end of the COC period about the transition process to ensure the member has continuity of service with their new or in-network provider.

Finding: The Plan did not inform member 30 calendar days before the end of the COC period about the transition process.

In the interview, the Plan stated that members are only notified initially by the Plan of the approval decision and at end of the COC via written notification letter. The Plan does not notify members 30 days prior to the end of the COC period. The Plan also stated that it recognized the deficiency, cited lack of monitoring and leadership, noted the need to train staff, implement and monitor policy and procedures.

The Plans' Member Handbook (Issued: 2020) and website Frequently Asked Questions did not include information about the process of notification before the end of the COC period and about the process to transition the member's care to an in-network provider at the end of the COC period.

Without a system in place to ensure that members are notified timely of the end of the COC period and in-network transition provider process, members' care may be delayed or impacted.

Recommendation: Implement and monitor a process to ensure that members are notified of the end of the COC period and in-network transition process 30 calendar days prior to the end of the COC period.

2.4.2 COC Services

The Plan must provide COC with an out-of-network provider based on the following reasons: 1. The Plan is able to determine that the member has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider), 2. The provider is willing to accept the higher of the Plan's contract rates or Medi-Cal Fee for Service rates, 3. The provider meets the Plan's applicable professional standards and has no disqualifying quality of care issues, 4. The provider is a California State Plan approved provider, 5. The provider supplies the Plan with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations. (*APL 18-008: Continuity of Care for Medi-Cal Members who Transition into Medi-Cal Managed Care (Revised: 07/10/2018))*

The Plan's *Policy and Procedure MM-UM-021: Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care* (Reviewed: 06/01/2016*),* lists COC requirements related to COC out of network which mirrors the APL requirements.

Finding: The Plan did not follow its COC policy and procedure and APL requirements when evaluating or making a decision for COC members with an out of-network provider.

In the verification study of COC service requests, the following was revealed:

- In one of ten COC service requests, the Plan did not implement its policy to provide COC services. The out-of-network provider approved by the Plan was not the member's requested provider. The COC approval was only for one visit instead of up to 12 months of COC services.
- In addition, four of ten COC service requests revealed that the Plan denied the services using the wrong criteria.

According to the Plan, the root cause was unavailability of leadership and reports, as well as a lack of training and need to update standardized documents. The Plan recognized the need for improvement in the department.

Without an effective process in place for reviewing COC requests and utilization of criteria for decision making may impact and delay medically necessary services needed by members.

Recommendation: Implement policies and procedures to ensure that appropriate processes are applied for COC service requests.

3.5	PROVIDER DIRECTORY

3.5.1 - Online Provider Directory

The Plan is required to distribute a Provider Directory that includes the following information: The name, provider number, address and telephone number of each service location. In the case of a medical group/foundation or IPA, the medical group/foundation or IPA name, provider number, address, telephone number shall appear for each physician provider. It shall also include the hours and days when each of these facilities is open, the services and benefits available, including which, if any, non-English languages spoken, the telephone number to call after normal business hours, accessibility symbols approved by DHCS, and identification of providers that are not accepting new patients. *(Contract, Exhibit A, Attachment 13 (E))*

The Plan is required to ensure the accuracy of the information in the Plan's Provider Directory or directories, and shall, at least annually, review, and update the entire Provider Directory or directories for each product offered. (*Health and Safety Code, section 1367.27 (l (1))*

Plan Policy and Procedure CSC-001 and CSC/OSE-001 Maintaining and Updating Provider Directories (Reviewed 05/18/2020), states that the Plan's online directories will be updated weekly and the printed directories on a monthly basis. Potential provider inaccuracies may be reported by members and other persons. Providers may report updates through the Plan's website. Errors will be updated within 30 days. The Provider Directories are reviewed and updated at least annually.

Finding: The Plan's electronic and online Provider Directories contained inaccurate information.

A verification study was conducted to test the accuracy of the Plan's Provider Directory. The review included 22 providers: 11 PCP and 11 specialty care physicians from the Plan.

Review of *Medi-Cal Provider Directories* (updated: 04/01/2021) electronic directories, Volumes 1 and 2 disclosed different types of inaccuracies as follows:

- There were 11 providers with different business hours.

- Three providers with incorrect addresses.
- Three providers who did not work at the location.
- Two providers whose telephone numbers were disconnected or no longer in service.

The 22 providers were also verified with the online Provider Directory. There were three providers who had different business hours than those listed on the electronic copy.

The Plan conducts a yearly Provider Directory accuracy assessment. The assessment disclosed accuracy rates across all lines of business. The accuracy rate for physician location was 91 percent and physician phone number 96 percent.

During the interview, the Plan stated the electronic Provider Directory is updated monthly and the online Provider Directory is updated weekly. The Plan's Provider Groups are responsible to update the Plan related to changes for their network providers and submit changes through the Plan's Provider Portal. The Plan's contracted vendor verifies the Plan's Provider Directory information.

The Plan relies on provider-based notifications for updating the Provider Directory and a contracted vendor to validate the accuracy of the Plan's Provider Directory. The Plan does not have other routine processes such as internal audits and testing of directory accuracy.

Members may have difficulty finding a provider for care based on inaccurate information listed on the Provider Directory which could lead to delay of services.

Recommendation: Implement routine and monitoring processes to ensure accurate information is in the Provider Directories.

3.8	NON-EMERGENCY MEDICAL TRANSPORTATION NON-MEDICAL TRANSPORTATION

3.8.1 Medi-Cal Enrollment of NEMT an NMT Providers

The Plan is responsible to ensure that all Medi-Cal Plan's network providers are enrolled in the Medi-Cal program. The Plan has the option to develop and implement a Managed Care provider screening and enrollment process that meets the requirements of this APL, or they may direct their network providers to enroll through a state-level enrollment pathway (DHCS Provider Enrollment Division). (*APL 19-004, Provider Credentialing/Re-credentialing and Screening/Enrollment (Issued: 06/12/2019))*

The Plans that rely on DHCS Provider Enrollment Division (PED) must direct new providers to the process outlined in the DHCS guidance. The providers who successfully complete the emergency enrollment application process through the PED portal will be granted an enrollment for 60 days. *(APL 20-004 Emergency Guidance for Medi-Cal Managed Care Health Care Plans in Response to COVID-19 (Issued: 08/18/2020))*

The Plans are responsible for ensuring that their subcontractors and delegated entities comply with all applicable state and federal laws and regulations; Contract requirements; reporting requirements; and other DHCS guidance including, but not limited to APLs. The Plan must have in place policies and procedures to communicate these requirements to all subcontractors and delegated entities. (*APL 17-004, Subcontractual Relationships and Delegation* (*Issued: 04/18/2017))*

The Plan's *Policy and Procedure PNMCRM-022* (Reviewed: 01/28/2021), states the Plan will ensure that all network providers that have a state level enrollment pathway are screened and enrolled in the Medi-Cal program and will rely on the enrollment and screening results conducted by DHCS. In addition, Screening and Enrollment Process states prior to initiation of a new contract and application for participation in the network, the Plan will notify the prospective providers of the enrollment and screening requirements and process, including the provider's right to enroll directly through DHCS, and have the provider attest to whether the provider is currently enrolled. Providers who are not enrolled are not eligible to enter into full agreement with the Plan and may not participate in the Plan network until such time the enrollment is approved.

Finding: The Plan did not ensure that its NEMT and NMT subcontractors or vendors were enrolled in the Medi-Cal program during the audit period.

A review of NEMT and NMT verification study files revealed one out of 15 NEMT and one out of the 11 NMT sub-subcontractor or vendors who were rendering services to members were not enrolled in the Medi-Cal program.

During the interview, it was discovered that the Plan did not communicate APL 20-004 requirements to its contractors or sub-subcontractors or vendors. The Plan has a policy and process in place for screening the subcontractors or vendors; however, it was not fully implemented.

NEMT and NMT provider enrollment in the Medi-Cal program requires verification of vans, drivers, and businesses they operate to meet all certification standards and regulatory requirements. Transportation services by unenrolled providers may subject members to inadequate and unsafe conditions.

This is a repeat of prior audit finding **2.4.1 – NEMT Providers not Enrolled in Medi-Cal**.

Recommendation: Implement policies and procedures to ensure the Plan's transportation providers are enrolled in the Medi-Cal program and comply with all requirements.

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 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 resolve each grievance and provide notice to the member as quickly as the member's health condition requires, within 30 calendar days from the date the Plan receives the grievance. The Plan is required to notify the member of the grievance resolution in a written member notice. *(CCR, Title 28, section 1300.68 (a) and (d)(3))*

The Plans are required to comply with the State's established time frame of 30 calendar days for grievance resolution. In addition, the Plan shall establish, implement, and maintain a Grievance and Appeal System to ensure the receipt, review, and resolution of G&A. (*APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments (Issued: 05/09/2017))*

The Plan's *Policy and Procedure AG-008: Grievance Process for Members* (Reviewed*:* 04/19/2019), describes the Plan's process for timely resolution of member grievances in accordance with federal and state laws. The Plan provides written resolution that contains a clear and concise explanation of the Appeals and Grievances Department decision. For the expedited grievance, the Plan will provide a resolution letter within 72 hours of the receipt and for the standard grievance the Plan will send a written resolution letter to the member or authorized representative within 30 calendar days.

Finding: The Plan's Grievance Department did not resolve and send grievance resolution letters to members.

A verification study of 84 standard and 26 expedited grievances files confirmed the following deficiencies:

- 14 standard grievance resolution letters were not sent at all to members.
- Ten expedited grievance resolution letters were not sent at all to members.

During the interview, the Plan stated that they did not process and resolve 10,230 standard and expedited grievance resolution letters and they failed due to turnover and subsequent shortage of staff, lack of training, COVID-19 pandemic and resulting telework transition, and managerial staff's failure to effectively monitor G&A Department's resources.

When the Plan does not notify members of the resolution of grievances in a timely manner, members may not have all the information they need to make their health care decisions and pursue their rights.

Recommendation: Develop and implement policies and procedures to ensure the Plan resolves and sends grievance resolutions to members.

4.1.2 Members Rights Attachment

The Plan is required to use "Your Rights" Attachment when sending notification letters to members. Your Rights Attachments informs beneficiaries of critical appeal rights. The "Your Rights" attachment sent out to beneficiaries who receive a NOA will contain general information on State Hearing and Independent Medical Review rights, the notice will primarily inform the beneficiary on how to request an appeal with the Plan. (*APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachment (Issued: 05/09/2017)*

The Plans must notify members who received a NAR that they have an additional 120 days over and above the initial 120 days allowed to request State Fair Hearing rights information with the NAR at the time of mailing, the Plan must call the member at the time the NAR is being mailed to notify the member of the right to request a State Fair Hearing within 240 days from the date of the NAR. (*Supplemental to APL 17-006: Emergency State Fair Hearing Timeframe Changes* (*Issued: 03/2020))*

Finding: The Plan included incorrect State Fair Hearing information with grievance extension letters sent to members.

A review of 84 standard grievance files revealed that eight files with an extension letter did not include the correct State Fair Hearing information. During the interview, the Plan stated that the templates were overlooked by the Compliance and Grievance Departments responsible for changes.

If written member information is not updated with current information, such as with new timeframes on when to file a State Hearing, members may be prevented from exercising

their right to file in a timely manner.

Recommendation: Develop and implement a process to ensure that attachments sent to members by the Grievance Department are consistent with requirements.

4.1.3 Grievances Resolution Timeframes

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 must resolve each grievance and provide notice, as expeditiously as the member's health condition requires, within State established time frames that may not exceed the time frames. If the Plan extends the time frame not at the request of the member, the Plan must make reasonable efforts to give the member prompt verbal notice of the delay. *(Title 42 CFR, section 438.408 Resolution and Notification)*

The Plan is required to establish a grievance system that tracks and monitors grievances received by the Plan, or any entity with delegated authority to receive or respond to grievances. The system shall monitor the number of grievance received and resolved; and the number of grievances pending over 30 calendar days. (*CCR, Title 28, section 1300.68 (a))*

The G&A System shall include the reporting procedures in order to improve the Plan's policies and procedures. The Plan is required to establish and maintain a system of aging of G&A that are pending and unresolved for 30 calendar days or more. (*APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments (Issued: 05/09/2017))*

The Plan's *Policy and Procedure AG-008: Grievance Process for Members* (Reviewed*:* 04/19/2019), describes the Plan's process for timely resolution of member grievances in accordance with federal and state laws. The Plan provides written resolution that contains a clear and concise explanation of the G&A Department decision. For the expedited grievance the Plan will provide a resolution letter within 72 hours of the receipt and for the standard grievance send a written resolution letter to the member or authorized representative within 30 calendar days.

Finding: The Plan did not send grievance resolution letters when a resolution was not reached within 30 calendar days. In addition, the Plan did not notify members of the

status and estimated resolution date when the resolution was not reached within 30 calendar days.

A review of 71 verification files for quality of service grievances revealed that 62 of 71 files reviewed were late with delays ranging from 32 to 244 days.

During the interview, the Plan stated the Plan's failure to provide members with timely notifications of written resolution was due to the following reasons: turnover of the managerial staff in the G&A Department, COVID-19 pandemic, the Plan's system was not efficient at providing appropriate alerts, and managerial staff's failure to effectively monitor the G&A Department's resources to ensure notification letter timelines. In addition, the Plan stated that the current Process of Communication Tracking System did not contain the capability to track grievances beyond 30 calendar days. A review of the Plan's G&A Department process revealed the Plan did not monitor that member resolution letters were sent in a timely manner and ensure the Plan's system was effective in providing necessary alerts to management.

The Plan's failure to adhere to the required timeframes for resolving grievances may potentially lead to delay in care and treatment of members.

Recommendation: Develop, implement, and monitor effective procedures to ensure that grievance resolution system and notification process aligns with the Contract requirements.

4.1.4 Resolution Letter Decisions

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 is required to establish and maintain written procedures for the submittal, processing, and resolution of all member grievance 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 22, 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 its decision

including all criteria and clinical reasons related to medical necessity. (*Health and Safety Code, section 1368 (5))*

The Plan's written resolution letter shall contain a clear and concise explanation of the Plan's decision. (*APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments (Issued: 05/09/2017))*

The Plan's *Policy and Procedure AG-008: Grievance Process for Members* (Reviewed*:* 04/19/2019), states the Plan staff will gather all clinical and non-clinical data relevant to the subject of the grievance. The Plan staff may contact all respective parties involved in the grievance. The Plan will fully investigate the grievances and provide written responses with the reasons for its decision.

Finding: The Plan did not send grievance resolution letters with clear and conclusive explanation of the Plan's decisions to members.

A review of 84 standard grievance files showed that 17 grievance resolution letters did not have a clear and conclusive decision; for example, the letters included statements use of peer review not specific to quality of care, referring to Quality Improvement Department or Committee for final decision, or no final decision was provided.

During the interview, the Plan staff acknowledged that the existing language in grievance resolution letters was not appropriate in all cases and did not always address patient concerns.

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.

Recommendation: Develop and implement policy and procedures to ensure that grievance resolution letters include a clear and conclusive explanation of the reasons for the Plan's decision.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Local Health Initiative Authority for Los Angeles County dba L.A. Care Health Plan
AUDIT PERIOD: July 1, 2019 through June 30, 2021 **DATE OF AUDIT: July 12, 2021 through July 23, 2021**

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.2	FRAUD, WASTE AND ABUSE

6.2.1 Annual Overpayment Reporting

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

The Plan is required to have a mechanism for a network provider to report to the Plan when it has received an overpayment, to return the overpayment to the Plan within 60 calendar days after the date on which the overpayment was identified, and to notify the Plan in writing of the reason for the overpayment. In addition, the Plan must report annually to the State on their recoveries of overpayments in accordance with Title 42 CFR, section 438.608(d)(3). (*Contract, Exhibit E, Attachment 2 (34B and C))*

The federal regulation section for treatment of recoveries made by the Plan of overpayments to providers requires that each Plan must report annually to the State on their recoveries of overpayments. *(Title 42 CFR, section 438.608(d))*

The Plan is required to create an internal retention and documentation process for recovery of all overpayments and review quarterly for accuracy. The Plan is required to report annually to DHCS of their recoveries of overpayments, including those made to a network provider that was otherwise excluded from participation in the Medicaid program and those made to a network provider due to fraud, waste, or abuse. These reports are required to be submitted through the existing rate setting process in a manner specified by DHCS. (*APL 17-003: Treatment of Recoveries made by the Managed Care Health Plan of Overpayments to Providers (Issued: 03/20/2017))*

The Plan *Policy and Procedure PI-200: Payment Integrity Post-Payment Review* (Reviewed: 08/13/2019), states that the Plan payment integrity post payment review seeks to identify overutilization of services or other practices that directly or indirectly result in unnecessary costs to Medicaid and/or Medicare programs. The process is monitored through the claims process based on payment integrity outcomes from post-payment documentation review.

Finding: The Plan's policy and procedures were not updated and operationalized to include Contract and APL requirements.

A review of the Plan's policy and procedure PI-200 revealed that it did not address Contract and APL requirements regarding reporting of the annual recovery of the overpayments to DHCS. During the interview, the Plan stated that the Plan's Compliance Department is in-charge of informing the head of the related Departments of the new APL changes related to services. The head of the related Department is responsible for revising the policy, procedures, and implementing the new changes in the Department. However, the Plan did not update its policy and procedures.

If the Plan does not have a policy and procedure for the reporting of an annual overpayment recovery to the State, there is a risk of failure to detect fraud, waste, or abuse.

Recommendation: Develop and implement policy and procedures to ensure the annual reporting of overpayment recoveries comply with APL requirements.