DEPARTMENT OF HEALTH CARE SERVICES
AUDITS AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
RANCHO CUCAMONGA

REPORT ON THE MEDICAL AUDIT OF

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

2023

Contract Number:	04-36069
Audit Period:	July 1, 2021 Through January 31, 2023
Dates of Audit:	February 27, 2023 Through March 10, 2023
Report Issued:	November 3, 2023

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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 (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 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. 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 29 Participating Physician Groups (PPGs) who receive a capitated payment for each member. In addition, the Plan utilizes 43 delegates to provide services to Medi-Cal members.

As of January 31, 2023, the Plan's total enrollment by product lines are as follows: 2,820,138 Medi-Cal (Plan Partners and MCLA), 122,279 L.A. Care Covered California, 49,564 Homecare Workers Health Care Plan, and 17,702 Cal Medi-Connect. As of December 5, 2022, the Plan's enrollment population for its delegates is: 1,295,154.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period July 1, 2021 through January 31, 2023. The audit was conducted from February 27, 2023 through March 10, 2023. The audit consisted of document review, verification studies, and interviews with Plan personnel and a delegate entity.

An Exit Conference with the Plan was held on October 18, 2023. 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 November 2, 2023, the Plan submitted a response after the Exit Conference.

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

The prior DHCS medical audit report issued on February 3, 2022, (audit period July 1, 2019 through June 30, 2021) identified deficiencies incorporated into a Corrective Action Plan (CAP). The prior year CAP was open as of October 9, 2023. The Plan is working with Managed Care Quality and Monitoring Division (MCQMD) to implement the CAP and correct the deficiencies identified in the DHCS audit report.

The summary of findings follows:

Category 1 – Utilization Management

The Plan is required to ensure that a Plan or contracting physician is available 24 hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized members in an emergency department. The Plan did not ensure that medical necessity decisions for post-stabilization services were made by qualified medical personnel.

The Plan is required to ensure that the UM program includes an established specialty referral system to track and monitor referrals requiring prior authorization through the Plan. The Plan did not have a system to track and monitor specialty referrals requiring prior authorization through the Plan.

The Plan is required to include within the UM program mechanisms to detect both under and over-utilization of health care services. The Plan did not have a mechanism to detect under and over-utilization of health care services.

The Plan is required to obtain 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 it obtained members' written consent for authorized representation to file appeals on their behalf.

The Plan shall ensure that their delegates comply with all applicable state and federal laws and regulations, and contract requirements. The Plan did not ensure that one of its delegated entities (Delegated Entity A), complied with all UM and prior authorization requirements.

The Plan shall collect and review their subcontractors' ownership and control disclosure information. The Plan did not collect and review ownership and control disclosure information for Delegated Entity B.

The Plan is required to alert the contract manager within three business days upon discovery that a subcontractor is out of compliance with the subcontractor ownership and control disclosure requirements. The Plan did not notify the contract manager within three business days that Delegated Entity B was out of compliance with the ownership and control disclosure requirements.

Category 2 – Case Management and Coordination of Care (COC)

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 their 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

Review of the Plan's Access and Availability of Care yielded no findings.

Category 4 – Member's Rights

The Plan is required to ensure that every grievance submitted is reported to an appropriate level i.e., Quality of Care (QOC) versus Quality of Service (QOS). The Plan did not properly classify QOC or Quality of Service (QOS) grievances.

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

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 the members' QOC grievances within 30 days of receipt of the grievance.

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

The Plan is required to obtain 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 a 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 providers within ten working days after being placed on active status.

Category 6 – Administrative and Organizational Capacity

Review of test work was isolated to systems relating to Fraud, Waste, and Abuse and yielded no findings.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The audit period was July 1, 2021 through January 31, 2023. The audit was conducted from February 27, 2023 through March 10, 2023. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies to determine that policies were implemented and effective. Documents were reviewed and interviews were conducted with Plan representatives and a delegated entity.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests (PA): 25 medical PA were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Appeal Process: 26 medical appeal requests were reviewed for appropriate and timely adjudication.

Delegation of UM: 7 PA requests from Delegated Entity A were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

California Children's Services (CCS): 12 medical records were reviewed for evidence of coordination of care between the Plan and CCS providers.

IHA: 22 medical records were reviewed to confirm completion of IHAs and 30 were reviewed for completion of BLS tests.

COC: 10 medical records were reviewed to evaluate timeliness and appropriate determination of the COC request.

Behavioral Health Treatment: 20 member files were reviewed to confirm coordination of care and fulfillment of behavioral health requirements.

Category 3 – Access and Availability of Care

Emergency Service and Family Planning Claims: 15 emergency service claims and 15 family planning claims were reviewed for appropriate and timely adjudication.

Non-Emergency Medical Transportation (NEMT): 15 records were reviewed to confirm compliance with NEMT requirements.

Non-Medical Transportation (NMT): 15 records were reviewed to confirm compliance with NMT requirements.

Category 4 – Member's Rights

Grievance Procedures: 25 quality of care and 20 quality of service grievance cases were reviewed for timely resolution, appropriate response to complainant, and submission to the appropriate level for review. 30 exempt grievances and 20 inquiry calls were reviewed for proper classification and routing to the appropriate level for review.

Confidentiality Rights: 15 cases were reviewed for reporting of privacy incidents to DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer within the required timeframes.

Category 5 – Quality Management

Quality Improvement (QI) System: 18 potential quality incident files were reviewed for proper decision-making and effective actions taken to address needed quality improvements.

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

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse Reporting: 17 cases were reviewed for proper reporting of suspected Fraud, Waste, and Abuse (FWA) to DHCS within the required time frame.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
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CATEGORY 1 - UTILIZATION MANAGEMENT

1.1	UTILIZATION MANAGEMENT PROGRAM REFERRAL TRACKING SYSTEM

1.1.1 Medical Director Oversight of Post-Stabilization Authorizations

The Plan shall maintain a full-time physician as medical director pursuant to 22 Code of California Regulations (CCR) Section 53857 whose responsibilities shall include ensuring that medical decisions are rendered by qualified medical personnel. *(Contract, Exhibit A, Attachment 1 (6)(A))*

The Plan is financially responsible for post-stabilization care services obtained within or outside the Plan's network. The Plan must give the treating physician the opportunity to consult with a Plan physician and the treating physician may continue with care of the patient until a Plan physician is reached or one of the criteria of 42 Code of Federal Regulations (CFR) section 422.133(c)(3) is met. *(Contract, Exhibit A, Attachment 8 (13)(I))*

The Plan shall ensure that a Plan or contracting physician is available 24 hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized members in an emergency department, if necessary. *(Contract, Exhibit A, Attachment 9 (7)(C))*

Finding: The Plan did not ensure that medical necessity decisions for post-stabilization services were made by qualified medical personnel.

Plan Policy MMUM-002 *Referral Request Management (effective date 9/28/2022*), stated a peer reviewer means a physician, pharmacist, or non-physician doctoral level behavioral practitioner bearing a valid unrestricted California license and who is qualified and competent to evaluate the specific clinical issue involved in the referral/review determination. Only qualified health care professional can make decisions based on medical necessity. Non-clinical staff do not interpret clinical records. While the Plan had a process in place to ensure that medical necessity decisions for post-stabilization services were made by qualified medical personnel, the Plan did not operationalize their written process and did not provide documentation to ensure that post-stabilization service decisions were made by qualified medical personnel.

During the interview, the Plan stated they used licensed vocational nurses (LVN) after hours and on weekends for post-stabilization authorization approvals. If the LVN denies services; the LVN will refer the case to the Medical Director for review.

However, the Plan could not produce documentation that post-stabilization services determinations were made by qualified medical personnel.

The lack of physician involvement in post-stabilization care decisions may lead to inappropriate patient care.

Recommendation: Revise and implement policies and procedures to track and monitor that post-stabilization services determinations are made by qualified medical personnel.

1.1.2 Referral Tracking

The Plan is required to ensure that the UM program includes established specialty referral system to track and monitor referrals including those that require prior authorization through the Plan. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. (*Contract, Exhibit A, Attachment 5 (1)(F)*)

Plan Policy MMUM-002, *Referral Request Management (effective date 12/15/2022),* stated the Plan maintains current processes and guidelines for reviewing requests for authorization and making UM determinations for health care services requiring authorization.

Finding: The Plan did not track and monitor specialty referrals requiring prior authorization through the Plan.

Plan policy MMUM-002 stated the Plan maintains current processes and guidelines for reviewing requests for authorization and making UM determination, as well as subsequent referral tracking. While the Plan had a process in place to ensure review of all incoming prior authorization requests, the Plan did not operationalize their written process for specialty referral tracking, monitoring, or for documenting contract required metrics such as authorized, denied, deferred, or modified referrals.

In addition, the Plan UM committee minutes did not document any referral tracking or monitoring of metrics.

During the interview, the Plan stated that they did not track or monitor specialty referrals but are in the process of developing that function in the UM system. Therefore, the Plan

did not track and monitor specialty referrals requiring prior authorization through the Plan.

If the Plan does not track and monitor specialty referrals requiring prior authorizations, it may result in delay in medically necessary services. Ultimately the lack of capabilities to track and monitor 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 prior authorizations.

1.1.3 Under and Over-Utilization

The Plan shall include within the UM program mechanisms to detect both under- and over-utilization of health care services. *(Contract, Exhibit A, Attachment 5 (4))*

Plan policy MMUM 061 *Over/Under Utilization Monitoring, Detection and Correction (effective date 9/28/2022*), stated the UM department monitors over- and under-utilization for selected activities using developed UM measures to identify potential patterns and trends. The activities identify and monitor inappropriate utilization and/or care provided in an inappropriate setting to assure that these are not indicative of barriers to accessibility for routine health care services and that care is not delayed or withheld for any reason.

Finding: The Plan did not have a mechanism to detect under- and over-utilization of health care services.

Although the Plan policy stated the UM department monitors over- and under-utilization for selected activities using developed UM measures to identify potential patterns and trends; the Plan did not have a mechanism to detect under and over-utilization of health care services.

During the interviews, the Plan stated that they do not have systems in place to gather data and develop under- and over-utilization reports. In addition, a review of UM, Quality Improvement, Compliance and Quality Committee, and Board of Governors meeting minutes demonstrated a lack of discussion and documentation regarding under- and over-utilization of medical services.

If utilization of services and procedures by the Plan is not monitored, the Plan cannot ensure that delivered services are medically necessary, provided in accordance with evidence-based clinical practice guidelines, and in a cost-effective manner.

Recommendation: Develop and implement processes to detect under and over-utilization of health care services. Integrate reports on under- and over utilization to UM, Quality Improvement, Compliance and Quality Committees to inform quality monitoring and improvement activities.

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 enrollee, a provider or an authorized representative may request an appeal or file a grievance on behalf of an enrollee. *(42 CFR section 438.402(c)(1)(ii))*

Plan Policy AG-007, *Appeals Process for Members (effective date 6/21/2022),* stated that if anyone other than the member files an appeal or grievance, the Appeals and Grievances Department will require that an Authorized Representative (Agent) form be completed, in addition to a written statement appointing an individual as a representative or other documents appointing the Individual as the member's representative under applicable state law in order to accept the appeal.

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

Plan Policy *AG-007* stated that if anyone other than the member files an appeal or grievance, the Appeals and Grievances Department will require that an Authorized Representative form be completed, in addition to a written statement appointing an individual as a representative. However, the Plan did not obtain members' written consent when purportedly authorized representatives filed appeals on their behalf.

The verification study revealed the Plan processed three appeals that required an Authorization of Representation (AOR). All three of the appeals were lodged by family members without an AOR. Furthermore, the appeal notification letters were mailed to

the member's home and not to the authorized representative's mailing address

During the interview, the Plan stated these errors were attributed due to lack of staff training and oversight of its appeal process.

When the Plan does not obtain written member consent for appeals filed by representatives on member's behalf, the Plan is out of compliance with requirements pertaining to member appeals.

Recommendation: Revise and implement procedures to ensure the Plan obtains a member's written consent for authorized representation when an appeal is filed by a representative on behalf of a member.

1.5 DELEGATION OF UTILIZATION MANAGEMENT

1.5.1 Delegation of Utilization Management

The Plans are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, and contract requirements*. (All Plan Letter (APL) 17-004, (superseded by APL 23-006 effective 3-28-23), APL 17-006, and APL 19-009)*

The Plan and any entity with which it contracts for services that include utilization review or UM functions shall comply with Health and Safety Code (H&S) 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. *(H&S section 1367.01(a) and (b))*

Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the Plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations. *(H&S section 1367.01(h))*

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 that subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its

responsibilities 2) Ensures subcontractor meets standards set forth by the Plan and DHCS, and 3) Includes the continuous monitoring, evaluation, and approval of delegated functions. *(Contract, Exhibit A, Attachment 4 (6)(B)(1)(2)(3)) and Attachment 5 (5))*

Plan policy *EPO-001, Clinical Monitoring of Delegated Functions (effective date 5/16/2022)(superseded Plan policy CA-001)* states 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. In addition, the Plan retains the right, based on quality issues to approve, suspend, and terminate delegated entities.

Finding: The Plan did not ensure that one of its delegated entities (Delegated Entity A), complied with all UM and prior authorization requirements.

DHCS requested service data for all 317,456 Plan members assigned to Delegated Entity A, to determine compliance with UM requirements. In a written response, the Plan acknowledged that although Delegated Entity A was given the responsibility to carry out utilization management (UM) functions, this delegate lacked a prior authorization system from July 1, 2021 through October 30, 2022. As a result, routine services requested by members and providers did not go through a PA process to review and approve, modify, delay or deny requests for services based on medical necessity from July 1, 2021 through October 30, 2022. Additionally, Delegated Entity A did not have the required written policies and procedures establishing its process for reviewing requests for services based on medical necessity nor did it have policies and procedures to ensure that its decisions were consistent with criteria or guidelines that are supported by clinical principles and processes.

As noted in the prior year audit finding 1.5.1, the Plan explained that Delegated Entity A 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. During the current audit period, the Plan stated that from October 31, 2022, the Plan's delegate established a process for providers to request PAs related to specialty referrals through its online electronic consultation system. A verification study reviewed data from November 1, 2022 through January 31, 2023, to analyze the effect of recent PA system changes and for overall contract compliance for PA requirements. In a verification study for the 90-day study period from November 1, 2022 to January 31, 2023, Delegated Entity A was able to produce only 7 PAs for review; within this universe of 7 cases, Delegated Entity A demonstrated inconsistent use of criteria for medical necessity

determination and non-compliance with written provider notification requirements.

- Delegated Entity A utilized two guidelines for PA medical necessity determination: the delegated specialty internal medical criteria and the Expected Practices (EP) medical criteria. Delegated Entity A used the more stringent specialty criteria to deny 3 of 7 PA cases, although, the EP medical criteria was met. These 3 PA requests were ultimately denied for not meeting the delegate's specialist internal medical criteria.
- The Plan showed non-compliance with Contract requirements for provider notifications. For all 7 PA cases, there was no documented written provider notifications stating whether the PA was approved or denied, and did not comply with UM requirements.

In an interview, the Plan stated that they are helping Delegated Entity A on improving their system and are open to feedback. Although the Plan has put in place policies and procedures to conduct delegation oversight, the oversight procedures were ineffective in detecting Delegated Entity A lack of compliance with UM, Prior Authorization and notification requirements, as well as the delegate's lack of a compliant medical necessity review process.

This is a repeat of prior year finding 1.5.1 – Delegation of Utilization Management.

In the prior year audit, DHCS found the Plan did not ensure that Delegated Entity A complied with UM and PA requirements including generating compliant member notices with DHCS-approved Notice of Action (NOA) Member Rights attachments. As part of the CAP to address this particular finding, the Plan and Delegated Entity A implemented the system's member notification. However, the Plan was found to be non-compliant during the audit period and did not ensure that Delegated Entity A complied with all UM and PA requirements.

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

Recommendation: Revise and implement UM delegation oversight processes to ensure that Delegated Entity A is compliant with all UM and PA requirements, including systems to enable provider notifications and appropriate application of medical necessity criteria in its PA process.

1.5.2 Delegate and Subcontractor Ownership and Control Information

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 subcontract requirements as stated in *42 section CFR 438.230(b)(1), (c), 22 CCR sections 53250 and 53867, and All Plan Letter (APL) 17-004.* In addition, subcontractor must agree to comply with all applicable requirements of the DHCS and Medi-Cal Managed Care program. *(Contract, Exhibit A, Attachment 6 (14))*

The Plan must require each disclosing entity to disclose certain information, including the name, address, date of birth, and social security number of each person or other tax identification number of each corporation with an ownership or control interest in the disclosing entity. (*42 CFR section 455.104*)

The Plan is ultimately responsible for ensuring that their subcontractors and delegated entities comply with all applicable state and federal laws and regulations. Subcontractors are required to provide written disclosure of information on subcontractors' ownership and control. The Plan shall collect and review their subcontractors' ownership and control disclosure information as set forth in *42 CFR section 455.104*. The Plan must make the subcontractors' ownership and control disclosure information available, and upon request, this information is subject to audit by DHCS. *(APL 17-004, Subcontractual Relationships and Delegation)*

Plan policy EPO-001*, Clinical Monitoring of Delegated Functions (effective date 5/16/2022),* stated the Plan remains accountable for and has appropriate structures and mechanisms to oversee delegated activities. In addition, delegate must provide written disclosure of information regarding its ownership and control in compliance with *42 CFR section 438.608(c)(2).* The Plan requests its delegates to submit an attestation yearly, indicating that delegated activities are not subcontracted to a third-party entity without prior written consent or documentation that relevant ownership and control disclosure information was reviewed and collected.

Finding: The Plan did not collect and review ownership and control disclosure information for Delegated Entity B.

A review of the Plan's subcontractors' ownership and control disclosure information revealed, the Plan did not collect and review Delegated Entity B ownership and control

disclosure documentation such as: name, address, date of birth, and social security number of any person with an ownership or control interest.

During the interview, the Plan stated that not reviewing the delegate ownership and control attestation responses was attributed to human error.

This is a repeat finding from the prior years 2021 and 2019; 1.5.3 Oversight of Network Delegate and Subcontractor Ownership and Control and 1.1.1 Documentation of the Plan's Oversight of its Delegates and Subcontractors.

While the Plan is working on implementing the CAP to correct the deficiency identified in the prior medical audit, the CAP remains open and deficiencies persist.

When the Plan does not collect and review ownership and control disclosure information from its delegates, it cannot ensure that the delegates' owners and individuals with control interest are eligible for program participation.

Recommendation: Revise and implement policies and procedures to ensure collection and review of delegates' ownership and control disclosure information.

1.5.3 Notification to Contract Manager for the Subcontractor Ownership and Control Disclosure Requirements

The Plan is required to alert their Managed Care Operations Division (MCOD) contract manager within three business days upon discovery that a subcontractor is out of compliance with the subcontractor ownership and control disclosure requirements, and/or if a disclosure reveals any potential violation(s) of the ownership and control requirements. (*APL 17-004, Subcontractual Relationships and Delegation*)

Plan's policy EPO-001, *Clinical Monitoring of Delegated Functions (effective date 5/16/2022)*, stated the Plan requires the delegate to provide written disclosure of information regarding its ownership and control and shall provide such information to the Plan upon request. Also, if the Plan discovers that the delegate is not in compliance with these requirements or that a disclosure reveals any potential violation(s) of the ownership and control requirements, then the Plan shall disclose such information to its DHCS MCOD contract manager within three business days of such discovery.

Finding: The Plan did not notify the contract manager within three business days that Delegated Entity B was out of compliance with the ownership and control disclosure requirements.

Although the Plan's policy *EPO-001* stated the Plan shall disclose to the contract manager within three business days that its delegate is not in compliance with ownership and control disclosure requirements, the Plan did not notify the contract manager of Delegated Entity B being out of compliance.

During the interview, the Plan acknowledged they were not aware Delegated Entity B was out of compliance with ownership and control disclosure requirements.

Without reporting ownership and control disclosure information within a timely manner, the Plan cannot ensure providers are in compliance with the Medi-Cal program requirement.

Recommendation: Revise and implement procedures to ensure notification of ownership and control changes to the contract manager within three business days of discovery.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	**BASIC CASE MANAGEMENT** **CALIFORNIA CHILDREN'S SERVICES (CCS)** **EARLY INTERVENTION / DEVELOPMENTAL DISABILITIES** **INITIAL HEALTH ASSESSMENT (IHA)**

2.1.1 Initial Health Assessment

The Plan shall cover and ensure the provision of an IHA (comprehensive history and physical examination) in conformance with 22 CCR section 53851(b)(1) to each new member within 120 days of enrollment. *(Contract Exhibit A, Attachment 10 (3))*

All new Plan members must have a complete IHA within 120 calendar days of enrollment. The Plan must have written procedures for requiring healthcare providers to document all components of the IHA, or any applicable IHA exemption, in the Member's Medical Record (MMR) in a timely manner. Furthermore, the Plan must have written procedures for monitoring IHA completion within the required timeframes. *(Medi-Cal Managed Care Division Policy Letter No. 08-003, operative through December 31, 2022; APL 22-030, operative beginning January 1, 2023; Population Health Management (PHM) Policy Guide, p. 9, operative beginning January 1, 2023)*

Plan policy QI-047, *Initial Health Assessment (effective date 11/22/2022),* stated the Plan network providers shall cover and ensure the provision of 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.

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

Plan policy *QI-047*, stated the Plan's providers must ensure the completion of an IHA for each new member within 120 calendar days of enrollment. However, the Plan did not ensure completion of an IHA for new members within the required time frame.

The verification study revealed that 17 out of 22 medical records did not have complete IHAs within 120 days of enrollment for new members.

During the interview, the Plan stated that on a monthly basis they create a report of new

enrollees who are due for an IHA. These reports are uploaded to the Plan's provider portal to notify providers of new enrollees who need an IHA and to conduct outreach to new members for IHA completion. Although the Plan is able to identify the members who need an IHA, it did not ensure members had an IHA completed within the required time frame.

If IHAs are not provided in a timely manner, members' health needs may not be appropriately identified, increasing risk for injury or disease.

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

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 that their network providers provide verbal 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 six months of age and continuing until 72 months of age. (*All Plan Letter 20-016 Blood Lead Screening of Young Children)*

Every healthcare provider who performs a PHA of a child shall provide written or verbal anticipatory guidance to a parent or guardian of the child with regards to harmful exposure to lead. The anticipatory guidance must be provided at each PHA, starting at six months of age and continuing until 72 months of age *(17 CCR section 37100 (a)(1))*

Plan policy QI-048, *Quality Improvement (effective date 12/14/2022)*, stated that the Plan will ensure its network providers provide verbal or written anticipatory guidance to the parents or guardians 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 six months of age and continuing until 72 months of age.

Finding: The Plan did not ensure anticipatory guidance was provided to parents or

guardians of age-appropriate members.

Plan policy QI-048, stated the Plan will ensure its network providers provide oral or written anticipatory guidance to the parents or guardians of child members starting at six 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 26 out of 30 medical records did not have documentation that verbal or written anticipatory guidance was provided to parents or guardians of child members.

During the interview, the Plan stated they use the IHA audit tool checklist for medical record review to monitor the provision of lead screening. However, the Plan acknowledged the IHA audit tool did not include a task to monitor the provision of verbal or written anticipatory guidance to parents/guardians of infant/child.

If lead poisoning anticipatory guidance is not given to parents or guardians in a timely manner, it can result in further lead exposure and poisoning.

Recommendation: Revise and implement procedures to ensure the provision of verbal or written lead poisoning anticipatory guidance to parents or guardians of child members.

2.1.3 Blood Lead Screening (BLS) Tests

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. *(All Plan Letter (APL) 20-016, Blood Lead Screening of Young Children)*

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Plan policy QI-048, *Quality Improvement (effective date 12/14/2022)*, stated the Plan will ensure its 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.

The verification study revealed 20 out of 30 medical records 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 they create a list of children who missed the BLS test on a monthly basis. The Plan then uploads this member list to the Plan's provider portal to notify the PCPs of the members with missed BLS. Although the Plan is able to identify the members who missed the BLS test, the Plan did not ensure BLS tests were ultimately performed by the PCP.

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 procedures to ensure the provision of BLS tests to child members at ages one and two and document the reason for not performing a BLS test. Implement systems to ensure PCPs are providing the BLS test to children that have not taken the test.

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Misclassification of Grievances

The Plan is required to ensure that every grievance submitted is reported to an appropriate level, i.e., Quality of Care (QOC) versus quality of service. *(Contract, Exhibit A, Attachment 14 (2)(C))*

The Plan shall have in place a system in accordance with 22 CCR Section 53858;28 CCR sections 1300.68 and 1300.68.01; and 42 CFR 438.402-438.424. The Plan shall follow Grievance and Appeal requirements, and use all notice templates included in APL 17-006 (operative through August 30, 2022) and APL 21-011 (operative August 31, 2022). *(Contract, Exhibit A, Attachment 14, Provision 1)*

Plan policy AG-008, *Grievance Process for Members (effective 6/21/2022)*, stated if the Appeal & Grievance (A&G) Department incorrectly classifies a grievance it is considered a misclassification. Upon discovery of the misclassification the A&G Department will notify the member or Authorized Representative in writing regarding the correction.

Finding: The Plan did not properly classify QOC or Quality of Service (QOS) grievances.

The verification study revealed 6 grievances were misclassified as QOS when they should have been classified as QOC. The Plan did not have an effective system to ensure QOC grievances inaccurately classified as QOS grievances.

During the interview the Plan stated these errors were attributed to the staff's lack of training and misunderstanding of the grievance process. The Plan acknowledged systemic problems and opportunities for improvement of their grievance system. Misclassification of grievances may lead to missed investigations that result in unresolved member complaints, which can potentially lead to member harm.

Recommendation: Revise and implement policies and procedures and relevant systems to ensure proper classification when processing and resolving grievances.

4.1.2 Quality of Care (QOC) Grievances

The Plan shall implement and maintain procedures and the expedited review of grievances required under 42 CFR 438.402, 438.406, and 438.408; 28 CCR Sections 1300.68 and 1300.68.01; and 22 CCR Section 53858. *(Contract, Exhibit A, Attachment 14 (2)).* The Plan will ensure the participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to the Plan's Medical Director (MD). *(Contract, Exhibit A, Attachment 14 (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 17-006 and APL 21-011 (operative August 31, 2022), Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Plan policy AG-001, *Appeal and Grievances Oversight and Reporting (effective date 6/21/2022),* 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 Plan's MD for action. Also, all identified potential QOC cases are referred to the QI department for evaluation, investigation, resolution and tracking of the issue.

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

Although the Plan's policy *AG-001* stated the grievances are screened for medical QOC issues and immediately submitted to Plan's MD for action, the Plan did not implement this policy.

The verification study revealed that 25 out of 25 QOC grievances were not reviewed by a Medical Director. The Plan's process was to refer QOC grievances to the QI department for Potential Quality of Care Issues (PQI). This process does not ensure that QOC grievances are referred immediately to the Medical Director for action.

During the interview, the Plan acknowledged their PQI process was allowed six months to complete the PQI review. Therefore, this current process of six months deprives the members of immediate action and resolution by the Plan's Medical Director.

Failure to follow contract and legal requirements applicable to QOC grievances leads to a lack of medical director action and involvement in the grievance process. Substandard

and poor quality of medical care by providers might be missed, not be adequately investigated and addressed, and lead to medical harm to members.

Recommendation: Develop a process to ensure all QOC grievances are timely referred to the Medical Director for action and comply with all grievance review requirements.

4.1.3 Timely Resolution of Quality of Care Grievances

The Plan shall ensure the participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to the Plan's MD*. (Contract, Exhibit A, Attachment 14(2)(D))*

The Plan is required to establish and maintain written procedures for the submittal, processing, and resolution of all member grievances and complaints. *(22 CCR section 53858(a))*

The Plan's grievance system shall provide prompt review of grievances by the management or supervisory staff responsible for the service or operations which are the subject of the grievance. Resolved means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance. *(28 CCR section 1300.68(a)(4)(d)(2))*

The Plan is required to provide written resolution to the member that is dated within 30 days of receipt of the grievance. (*APL 17-006 and APL 21-011*)

In the event a grievance resolution is not reached within 30 days, the member shall be notified in writing by the Plan of the status of the grievance and shall be provided with an estimated completion date of resolution. Such notice shall include a statement notifying the member they may exercise their right to request a fair hearing. (22 *CCR section 53858*)

Plan policy AG-001, *Appeal and Grievances Oversight and Reporting (effective date 6/21/2022)* stated the Plan will ensure the participation of individuals with authority to require corrective action when quality of care issues are involved. The appeals and grievances are screened for medical QOC issues and immediately submitted to Plan's Medical Director for action. Also, all identified potential QOC cases are referred to the QI department for evaluation, investigation, resolution and tracking of the issue.

Finding: The Plan did not resolve the members' QOC grievances within 30 days of receipt of the grievance.

The Plan's current process is to refer all QOC grievances to the QI department for PQI investigation. The Plan did not resolve the members' QOC grievances within 30 days of receipt.

The verification study revealed 23 out of 25 QOC grievances were not resolved within 30 days. The following are examples of deficiencies identified:

- In 1 QOC grievance, a member suffered a serious injury and experienced unsafe conditions at a facility, the Plan closed the grievance by forwarding to QI for investigation and the member did not receive further communication regarding their grievance.
- In another QOC grievance, a member was given the wrong medicine and was having complications from the medication, the Plan closed the grievance by forwarding to QI for investigation and the member did not receive further communication regarding their grievance.
- In 2 QOC grievances, one member experienced a delay in getting an appointment for surgery with a urologist and one member experienced a delay in getting a specialty referral. The Plan closed the grievances by forwarding to QI for investigation and the members did not receive further communication regarding their grievances.

During the interview, the Plan stated their PQI process was allowed six months to complete the review and would have to revisit their grievance processing system. Therefore, the Plan is not in compliance with contractual requirements of resolving member's QOC grievances within 30 days.

This is a repeat finding of prior year finding - 4.1.1 - Grievances Letters.

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

Recommendation: Implement policy and procedure to ensure QOC grievances are resolved within 30 days. Implement a system to monitor timely resolution of grievances and incorporate timeliness reporting to UM, Quality Improvement, Compliance and Quality Committees.

4.1.4 Grievance Resolution Letters

The Plan is required to develop, implement, and maintain a Member Grievance System in accordance with 28 CCR sections 1300.68, and 1300.68.01 and 22 CCR 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 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. (*22 CCR 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. (*H&S section 1368(a)(5))*

The Plan's written resolution letter shall contain a clear and concise explanation of the Plan's decision. (*APL 17-006 and APL 21-011: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments)*

Plan policy AG-008, *Grievance Process for Members (effective date 6/21/2022),* stated the written resolution shall contain a clear and concise explanation of the grievance department decision.

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

The verification study revealed 23 out of 25 QOC grievance letters sent to members did not contain a clear explanation of the Plan's decision related to their grievance. The letters sent to members did not have a clear and concise explanation with respect to their submitted grievance. In addition, the resolution letters contained a template response that the issue would be reviewed in the QI department and due to confidentiality, the member would not get any correspondence about further actions.

During the interview, the Plan stated that the resolution letter that was being sent to members stated that their grievance was referred to QI for further investigation and did not address the members' concerns and did not offer a clear and concise explanation of the Plan's decision. Therefore, the Plan is not in compliance with contractual requirements.

This is a repeat of prior year finding - 4.1.4 Resolution Letter Decisions.

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.

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. *(42 CFR 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 17-006 and APL 21-011 Grievance and Appeals Requirements, Notice and "Your Rights")*

Plan policy AG-008, *Grievances Process for Members* (*effective date 6/21/2022),* stated, if anyone other than the member files a grievance, the Appeals and Grievances (A&G) department will ask for an Appointment of Representative (AOR) form or written statement appointing an individual as a representative or other appropriate papers appointing the individual as the member's representative under applicable state law in order to accept the grievance.

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 if anyone other than the member files a grievance, the A&G department will ask for an AOR form or written statement appointing an individual as the member's representative. However, the Plan did not obtain member's written consent before filing the grievance on their behalf.

A verification study revealed the Plan processed 9 out of 25 grievances that required member's written consent. Six out of 25 grievances were filed by family members

without AOR forms or written consent. In 3 out of 25 grievances an AOR was obtained however, acknowledgment and resolution letters were mailed to the member's home and not to the authorized representative's mailing address.

During the interview, the Plan stated these errors were attributed to lack of staff training and oversight of its grievance process.

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

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 (CAF) ❖
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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 date 4/28/2017),* stated that all new providers are required to complete new provider onboarding training within ten business days of their effective day. Contract and Relationship Management Unit will administer new provider onboarding training to directly contracted providers within ten business days of their active date.

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

The verification study revealed that the Plan did not conduct provider training within ten working days for 19 out of 20 newly contracted providers. In addition, during the interview, the Plan confirmed the outreach to newly contracted providers was not effective because the Plan did not follow up on providers that failed to attend their scheduled 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: Implement policies and procedures to ensure newly contracted providers receive training within the required timeframes.

DEPARTMENT OF HEALTH CARE SERVICES
AUDITS AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
RANCHO CUCAMONGA

REPORT ON THE MEDICAL AUDIT OF

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

2023

Contract Number:	03-75799 State Supported Services
Audit Period:	July 1, 2021 Through January 31, 2023
Date of Audit:	February 27, 2023 Through March 10, 2023
Report Issued:	November 3, 2023

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I. INTRODUCTION

This report presents the audit results of the Local Initiative Health Authority for Los Angeles County dba L.A. Care Health Plan (Plan) compliance and implementation of the State Supported Services Contract No. (03-75799) with the State of California. The Contract covers abortion services for the Plan.

The audit was conducted from February 27, 2023 through March 10, 2023. The audit covered the period from July 1, 2021 through January 31, 2023. It consisted of document reviews, a verification study, and interviews with the Plan's staff.

An Exit Conference with the Plan was held on October 18, 2023. There were no deficiencies identified for the audit of the Plan's State Supported Services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

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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's policy *CLM-029, Abortion Services (review date 6/28/2022),* stated *a*bortion services are covered by the Plan as a physician service. For outpatient services, no medical justification or prior authorization is required. Non-emergency inpatient hospitalization for the performance of abortion services requires authorization under the same criteria as other medical procedures.

The Plan provided information on covered services to members through their Member Handbook. The information stated that abortion services are available to members without a referral or prior authorization, members have a right to services in a timely manner, and members may self-refer to any certified family planning provider.

The verification study revealed the Plan appropriately processed abortion claims for payment and did not demonstrate any deficiencies related to State Supported Services.

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

RECOMMENDATION: None