

DHCS AUDITS AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
RANCHO CUCAMONGA SECTION

**REPORT ON THE MEDICAL AUDIT OF LOCAL
INITIATIVE HEALTH AUTHORITY FOR LOS
ANGELES COUNTY DBA: L.A. CARE HEALTH PLAN
2025**

Contract Number: 23-30232

Audit Period: February 1, 2024 — September 30, 2025

Dates of Audit: October 20, 2025 — October 31, 2025

Report Issued: May 8, 2026

TABLE OF CONTENTS

I.	INTRODUCTION	3
II.	EXECUTIVE SUMMARY	4
III.	SCOPE/AUDIT PROCEDURES	6
IV.	COMPLIANCE AUDIT FINDINGS	
	Category 1 – Utilization Management Program	8
	Category 4 – Grievances, Appeals, and Member Rights	12

I. INTRODUCTION

Local Initiative Health Authority for Los Angeles County, doing business as L.A. Care Health Plan (Plan), was established in 1997 as the local initiative Medi-Cal Managed Care Health Plan in Los Angeles County under the Two-Plan Medi-Cal Managed Care model. The Plan obtained a Knox-Keene license in April 1997.

The Plan provides managed care health services to Medi-Cal members under the provisions of the California 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 the Plan contracts with three health plans through capitated agreements. The Plan Partners are Anthem Blue Cross, Blue Shield of California Promise Health Plan, and Kaiser Foundation Health Plan, Inc. The Plan began providing coverage directly to Medi-Cal members under its line of business, Medi-Cal Care Los Angeles, in 2006. In addition, the Plan utilizes approximately 38 delegates to provide services to Medi-Cal members.

As of September 2025, the Plan's total enrollment by product lines is as follows: 2,296,419 Medi-Cal (Plan Partners), 29,555 Dual Eligible Special Needs Plan, 224,586 L.A. Care Covered California, 64 L.A. Care Covered CA Direct, and 51,261 PASC-SEIU. As of August 1, 2025, the Plan's member enrollment population is approximately 2,062,927.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of February 1, 2024, through September 30, 2025. The audit was conducted from October 20, 2025, through October 31, 2025. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on April 9, 2026. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On April 23, 2026, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management Program, Population Health Management and Coordination of Care, Network and Access to Care, Grievances, Appeals, and Member Rights, Quality Improvement (QI) and Health Equity Transformation Program, and Plan Administration and Organization.

The prior DHCS medical audit for the period of February 1, 2023, through January 31, 2024, was issued on January 16, 2025. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation and effectiveness of the Plan's prior year 2024 Corrective Action Plan.

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

The summary of the findings by category follows:

Category 1 – Utilization Management Program

The Plan is required to provide written responses regarding decisions to deny, delay, or modify health care services that include a clear and concise explanation of the reasons for the Plan's decision. Finding 1.2.1: The Plan did not ensure that Notice of Action (NOA) letters included a clear and concise explanation of the reason for its decision.

The Plan must maintain an adequate oversight procedure to ensure subcontractor's and downstream subcontractor's compliance with all QI or health equity delegated activities. Finding 1.4.1: The Plan did not ensure subcontractor compliance with delegated activities.

Category 2 – Population Health Management and Coordination of Care

There were no findings noted for this category during the audit period.

Category 3 – Network and Access to Care

There were no findings noted for this category during the audit period.

Category 4 – Grievances, Appeals, and Member Rights

The Plan is required to make reasonable efforts to provide members with oral notice of expedited resolutions. Finding 4.1.1: The Plan did not ensure that members received oral notice of expedited grievance decisions.

The Plan is required to refer Quality of Care (QOC) grievances to the Plan's Medical Director (MD). Finding 4.1.2: The Plan did not ensure that QOC grievances were submitted to the Plan's MD for action.

The Plan is required to make a reasonable effort to provide oral notice of expedited appeal decisions. Finding 4.2.1: The Plan did not ensure that members received oral notice of expedited appeal decisions.

The Plan is required to allow a member, a provider, or an authorized representative to act on the member's behalf—with the member's written consent—to request or file an appeal. Finding 4.2.2: The Plan did not ensure that members' written consent was obtained when a provider or authorized representative filed appeals on their behalf.

The Plan is required to ensure that members receive all information in a threshold language of their choice. Finding 4.2.3: The Plan did not ensure that members received all information in a threshold language of their choice.

Category 5 – Quality Improvement and Health Equity Transformation Program

There were no findings noted for this category during the audit period.

Category 6 – Plan Administration and Organization

There were no findings noted for this category during the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

DHCS conducted an audit of the Plan from October 20, 2025, through December 31, 2025, for the audit period of February 1, 2024, through September 30, 2025. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with the Plan's administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management Program

Prior Authorization Requests: Thirty-five prior authorization requests were reviewed to assess the consistent application of criteria, appropriate review, and the communication of results to members and providers.

Delegation of Utilization Management: Twenty-five prior authorization requests from Preferred Independent Practice Association (PIPA) of California were reviewed for appropriate adjudication.

Category 2 – Population Health Management and Coordination of Care

Initial Health Appointment: Fifteen medical records were reviewed to confirm completion of Initial Health Appointments, and 18 medical records were reviewed to confirm completion of blood lead screening tests.

Category 3 – Network and Access to Care

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

Category 4 – Grievances, Appeals, and Member Rights

Grievance Procedures: Thirty-six QOC and 22 quality of service grievance cases were reviewed for appropriate responses to the complainant and for submission to the appropriate level for review. Seven exempt grievances and 22 inquiry calls were reviewed for proper classification and routing to the appropriate level for review.

Appeal Process: Thirty-two prior authorization appeals were reviewed for appropriate adjudication.

Category 5 – Quality Improvement and Health Equity Transformation Program

QI System: Seventeen potential quality issue cases were reviewed to determine the effectiveness of actions taken to address improvements.

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

Category 6 – Plan Administration and Organization

Fraud, Waste, and Abuse: Fifteen fraud and abuse cases were reviewed to ensure that suspected fraud, waste, and abuse were reported to DHCS within the required timeframe.

Medi-Cal Suspended and Ineligible (S&I) Provider List and the Office of Inspector General (OIG) Database : Requested the Plan's tracking reports to verify monitoring of the S&I list and the OIG database for excluded/terminated, S&I providers and subcontractors. Selected 16 S&I providers and 7 OIG-listed providers to confirm compliance with contractual and regulatory requirements upon the Plan's identification of any adverse actions.

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management Program

1.2 Prior, Concurrent, and Retrospective Authorization Reviews

1.2.1 Clear and Concise Notice of Action Letters

A clear and concise explanation of the action that the Plan or its network provider has taken or intends to take must be provided, including a fully translated written notice with a fully translated clinical rationale for the Plan's decision at the point of each determination. *(Contract Exhibit A, Attachment III, 4.6.4 (E)(1))*

Responses regarding decisions to deny, delay, or modify health care services requested by providers must be communicated to the member in writing and must include a clear and concise explanation of the reasons for the Plan's decision. *(Health and Safety Code section 1367.01(h)(4))*

Plan policy, *MMUM-002 Referral Request Management* (reviewed 01/22/2025), states that adverse determinations require NOA letters that include: a statement of the action the health plan intends to take, and a clear and concise explanation of the reasons for the decision in easily understandable language.

Finding: The Plan did not ensure that NOA letters included a clear and concise explanation of the reason for their decision.

Plan policy MMUM-002 requires that NOA letters include a clear and concise explanation of the decision in language that members can easily understand. The Plan developed a standardized letter template system to meet contractual readability standards. For instance, the templates use simple language and short sentences to ensure clarity. However, the system lacked a quality control process to ensure letters clearly conveyed the rationale for the decision, which could lead to confusion and misunderstandings among members. Specifically, there was no review mechanism to check for consistency and accuracy in the explanations provided.

The verification study found that 5 of 20 NOA letters lacked clarity and failed to provide a concise explanation of the denial. This deviates from Plan policy MMUM-002, which requires NOA letters to include a clear and understandable explanation of the decision.

Examples of unclear language included:

- In response to an expedited liver transplant request for a 55-year-old member with end stage liver disease the Plan stated: “We did not receive enough information to review this ask. We need to know what service is being requested and why it is needed.”
- In response to a request for fluid drainage for a 61-year-old member with foot and ankle pain, the Plan stated: “We need to know what care is being asked. We need more information to review this request.”
- In response to a request for gender affirming surgery, the Plan stated: “We need to see a letter from a health expert who has experience taking care of transgender and gender diverse people.”

During the interview, the Plan acknowledged that the NOA letters lacked clarity. The Plan attributed this to the use of generalized templates designed to meet readability standards. However, these templates did not clearly and effectively communicate the specific reasons for denial or the next steps for members. Although a letter review team was implemented as a QI initiative, the Plan admitted that further improvements are needed.

When NOA letters are unclear and not concise, members may not understand why their request was denied or what steps they need to take to obtain services. This can lead to confusion, delays in care, and potential harm to members from unmet medical needs.

Recommendation: Implement policies and procedures to ensure that NOA letters are clear, concise, and tailored to the member’s specific case. Provide training to staff responsible for drafting and reviewing NOA letters to ensure compliance with policy and regulatory requirements.

1.4 Delegated Utilization Management Activities

1.4.1 Delegate Oversight Management and Implementation of Escalatory Measures

The Plan must maintain an adequate oversight procedure to ensure subcontractor’s and downstream subcontractor’s compliance with all QI or health equity delegated activities that, at a minimum: 1) Evaluates the subcontractor’s ability to perform delegated activities, including an initial review to ensure administrative capacity, task experience, and budgetary resources; 2) Ensures subcontractors meet standards set forth by the Plan and DHCS; and 3) Includes continuous monitoring, evaluation, and approval of delegated functions. (*Contract Exhibit A, Attachment III, 2.2.5 (B)(1)*)

The Plan must regularly monitor all functional areas delegated to subcontractors and impose corrective action and/or financial sanctions on subcontractors upon discovery of noncompliance with subcontractor agreements or Medi-Cal requirements. (*All Plan Letter (APL) 23-006, Delegation and Subcontractor Network Certification*)

Plan policy, *DOA-001 Delegation Oversight Audit* (revised 01/01/2024), states that repeated deficiencies of the same audit standard will trigger an escalation process that may lead to the imposition of a financial sanction. Once an audit deficiency is identified, the provider will receive technical assistance and be closely monitored. If the deficiency recurs in the next audit, the provider/Participating Physician Group will be escalated to the Sanctions Team for direct outreach, issuance of warning letters, and, if necessary, the imposition of sanctions.

Finding: The Plan did not ensure subcontractor compliance with delegated activities, resulting in repeated deficiencies and multiple corrective actions.

The Plan's annual oversight audit of PIPA issued multiple Corrective Action Plans addressing the same deficiencies over several years. Despite these repeated findings, the Plan did not escalate its corrective actions with the provider in accordance with its policy, which provides that repeated deficiencies in the same audit standard will trigger an escalation process that may lead to the imposition of a financial sanction. Examples of these repeated deficiencies include:

- Provider Network Adequacy – Third year repeat (e.g., insufficient number of primary care providers)
- Utilization Management – Third year repeat (e.g., delays in authorization processes)
- Specialty Referral – Fourth year repeat (e.g., long wait times for specialist appointments)
- Sterilization – Fourth year repeat (e.g., inadequate documentation of consent)

During the interview, the Plan reported that it had implemented a revised escalation process in early 2024. The process outlines a three-tiered approach: initial engagement with the provider, escalation to higher oversight levels, and, if compliance is not achieved, referral to the Sanctions Committee. However, the Plan could not demonstrate that this process was applied during the audit period. Specifically, there was no documentation showing that PIPA was escalated to the Sanctions Committee despite repeated deficiencies. This omission violates the Plan's policy DOA-001 and the requirements in APL 23-006.

When repeated deficiencies under the same audit standard occur and the Plan does not initiate the required escalation process, it cannot ensure that delegated entities are effectively addressing ongoing noncompliance. This lack of initiation may result in delays or denials of medical services for members, potentially leading to adverse health outcomes and harm.

Recommendation: Implement and document the Plan's delegation oversight and escalation processes to ensure that PIPA and other provider effectively correct repeat deficiencies.

COMPLIANCE AUDIT FINDINGS

Category 4 – Grievances, Appeals, and Member Rights

4.1 Member Grievance System and Oversight

4.1.1 Oral Notice of an Expedited Grievance Decision

The Plan must comply with all existing and future APLs. APLs and Policy Letters existing on the effective date of the Contract will be considered part of the Contract as if fully set forth herein. (*Contract Exhibit E, 1.1.2 (A)*)

Federal regulations require the Plan to make reasonable efforts to provide the member with oral notice of the expedited resolution. The Plan must apply this requirement of oral notice for expedited appeals to expedited grievances. (*APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates*)

Plan policy, *AG-008 Grievance Process* (reviewed 08/28/2025), states that upon resolution of an expedited grievance, the Plan makes reasonable efforts to notify the member or authorized representative both orally and in writing about the disposition or pending status of the grievance within 72 hours of receipt.

Finding: The Plan did not ensure that members received oral notice of expedited grievance decisions.

Plan policy AG-008 outlines the requirement for oral and written notification of expedited grievance resolutions. However, the Plan did not adhere to its policy in the cases reviewed.

The verification study found that in 5 of 14 expedited grievance samples, there was no documented evidence that oral notification was given to the member or their authorized representative. This deviates from APL 21-011, which requires reasonable efforts to provide oral notification, and the Plan's policy AG-008, which mandates reasonable efforts to provide both oral and written notification within 72 hours of receipt.

During the interview, the Plan acknowledged that it neither attempted nor provided oral notification in the identified cases. The Plan stated that this was due to staff shortages and gaps in staff training on contractual and internal policy requirements. Furthermore, the Plan lacked a process to ensure that oral notification was completed and tracked before case closure.

When members do not receive oral notification of their expedited grievance resolution, they may remain unaware of the outcome in a timely manner. This can delay their ability to make informed decisions about their care, potentially leading to adverse health outcomes and member harm.

Recommendation: Implement procedures to ensure that oral notification is attempted and documented for all expedited grievance resolutions. Establish monitoring mechanisms and system controls to verify compliance with oral notification standards.

4.1.2 Medical Director's Participation in Quality of Care Grievances

The Plan must have in place a member grievance and appeal system that complies with the Code of Federal Regulations (CFR), Title 42, sections 438.228 and 438.400 through 438.424; California Code of Regulations, Title 28, sections 1300.68 and 1300.68.01; and California Code of Regulations, Title 22, section 53858. The Plan must ensure that all grievance or appeals related to medical QOC issues be submitted to the Plan's MD for action. *(Contract Exhibit A, Attachment III, 4.6.1(D))*

Grievances related to medical QOC issues must be referred to the Plan's MD. The individual making the final decision on a grievance involving clinical issues must be a health care professional with clinical expertise in treating the member's condition or disease. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Plan policy, *AG-001 Appeals and Grievances Oversight and Reporting* (reviewed 01/09/2025), states that the Plan ensures the participation of individuals with the authority to require corrective action when QOC issues are involved. Grievances are to be screened for medical QOC issues and immediately submitted to the Plan's MD for action.

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

Plan policy AG-001 requires that all grievances involving medical QOC be submitted to the Plan's MD for action. However, in the cases reviewed, this requirement was not followed. Clinical staff continued to process QOC grievances without MD involvement, indicating a breakdown in the system in which required referrals were not made in accordance with policy.

The verification study revealed that 6 of 30 QOC grievances were not reviewed by an MD. This is a deviation from Plan policy AG-001, which requires that such grievances be submitted to the MD for action.

During the interview, the Plan acknowledged that QOC grievances were not submitted to the MD for action, as required by policy. The Plan continued processing QOC grievances without MD involvement. The Plan stated that gaps in staff training and a limited understanding of the revised procedures contributed to the oversight in referring these grievances to the MD.

This is a repeat of the prior year finding – 4.1.3 Quality of Care Medical Director Resolution.

Without review and resolution of QOC grievances by an MD, member complaints involving clinical concerns may not be evaluated by a qualified health care professional. This may result in missed opportunities to identify substandard care, delays in corrective action, and potential harm to members from unresolved issues. Consequently, members may experience delays in receiving appropriate, high-quality care.

Recommendation: Implement policy and procedures to ensure that all QOC grievances are submitted to the Plan’s MD for action. Provide targeted training to appeals and grievances staff to reinforce policy requirements and ensure consistent application.

4.2.1 Oral Notice of an Expedited Appeal Decision

The Plan must make a reasonable effort to provide oral notice of an expedited appeal decision. (*Contract Exhibit A, Attachment III, 4.6.6 (D)*)

Medi-Cal Managed Care Plans are required to make reasonable efforts to provide the member with oral notice of the expedited appeal resolution. Plans must comply with all other existing state regulations pertaining to expedited appeal handling.

(*APL 21-011, Grievance and Appeal Requirements, Notice and “Your Rights” Templates*)

Plan policy, *AG-007 Appeals Process for Members* (reviewed 04/16/2024), states that for expedited appeal resolutions, an appeals and grievances representative must make three reasonable efforts to provide the member or authorized representative with oral notification of the resolution.

Finding: The Plan did not ensure that members received oral notice of an expedited appeal decision.

Plan policy AG-007 requires appeals and grievances representatives to make three reasonable attempts to provide the member or authorized representative with oral notification of the expedited appeal resolution. However, in the cases reviewed, this process was not followed. The system failed to ensure that oral notification attempts were initiated or documented, resulting in a breakdown of the required outreach process.

The verification study found that in 12 of 22 expedited appeal samples, the Plan failed to make a reasonable effort to provide oral notification to its members or their authorized representatives; in these 12 cases, no attempt was documented. This deviates from the Plan's Contract and Plan policy AG-007, which requires the Plan to make reasonable efforts to orally notify members of expedited appeal resolutions.

During the interview, the Plan acknowledged that they neither attempted nor provided oral notifications in these cases. They attributed this to gaps in staff training and a misunderstanding of contractual requirements and internal policy. The failure to implement a structured process to ensure and track oral notification attempts may have contributed to the oversight, creating a disconnect between policy and practice.

When members do not receive oral notification of their expedited appeal resolution, they may be unable to make timely, informed health care decisions, increasing the risk of member harm.

Recommendation: Implement procedures to ensure that oral notification is attempted and documented for all expedited appeal resolutions. Provide targeted training for appeals and grievances staff to reinforce policy requirements and ensure consistent application. Establish monitoring mechanisms and system controls to verify compliance with oral notification standards before case closure.

4.2.2 Written Consent for Appeals

A member, a provider, or an authorized representative acting on behalf of a member and with the member's written consent, may request an appeal. (*Contract Exhibit A, Attachment III, 4.6.5 (A)*)

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

Plan policy, *AG-007 Appeals Process for Members* (effective 04/16/2024), states that if anyone other than the member files an appeal or grievance, the Appeals and Grievances Department will require written permission from the member.

Finding: The Plan did not ensure that members' written consent was obtained when a provider or authorized representative filed appeals on their behalf.

Plan policy AG-007 requires written permission from the member when an appeal is filed by someone other than the member. However, the Plan's desk level procedure (DLP), *DLP-12 Member and Provider Appeals* (revised 12/10/2024), states that treating providers may file an appeal on a member's behalf without the need for authorized representative documentation. This inconsistency between policy and procedure created confusion among staff, who, during the review period, followed the desk procedure and did not obtain written consent in 13 appeal cases.

The verification study found that the Plan processed 13 of 15 appeals made on a member's behalf without obtaining the member's written consent. This deviates from the Contract and the Plan's policy AG-007, which requires written consent when a provider or authorized representative makes an appeal on a member's behalf.

During the interview, the Plan acknowledged that staff misinterpreted the written consent requirement, assuming it was unnecessary when treating providers submitted appeals. According to Plan policy AG-007, written authorization from members is required when a third-party file an appeal. However, DLP-12 permits treating providers to submit appeals on a member's behalf without authorized representative documentation. Consequently, written consent was not obtained in 13 appeal cases.

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

When the Plan does not obtain a member's written consent before processing an appeal on the member's behalf, the member's right to autonomy is at risk. This may result in unauthorized medical care decisions and unauthorized access to the member's Protected Health Information.

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

4.2.3 Members Receive All Member Information in a Threshold Language of Their Choice

The Plan must establish policies and procedures to ensure members receive all member information in a threshold language or alternative format of their choice, as required by CFR, Title 42, section 438.10 and California Welfare and Institutions Code section 14029.91 (*Contract Exhibit A, Attachment III, 5.1.3 (F)(3)*)

The written Notice of Action and Notice of Appeal Resolution must meet all language and accessibility standards, including translation, font, and format requirements, as set forth in APL 21-004, *Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services*, federal and state law, and all requirements in the DHCS Contract. (*APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates*)

Plan policy, *AG-007 Appeals Process for Members* (effective 04/16/2024), states that the Appeals and Grievances Department forward any correspondence requiring translation to the Cultural and Linguistic Department at least three days prior to case closure. In all cases, the template will be translated into the member's threshold language.

Finding: The Plan did not ensure that members received all information in a threshold language of their choice.

Plan Policy AG-007 outlines the process for translating member correspondence, requiring the Appeals and Grievances Department to forward materials to Cultural and Linguistic Department for translation before case closure. However, this process was not effectively implemented or monitored. There was no clearly defined or consistently applied mechanism to confirm that all member communications were translated before being sent.

The verification study found that in 4 of 13 appeal cases, three acknowledgment letters and two resolution letters were sent to members without being translated into their preferred threshold language. This deviates from Plan policy AG-007 and regulatory requirements.

During the interview, the Plan acknowledged that it lacked a process for identifying missing critical elements, such as translation into threshold languages (languages spoken by a significant portion of the population), when sending Notice of Appeals Resolution letters to members. The Plan also stated that it did not have a pre-distribution quality control mechanism to ensure compliance with translation requirements.

When members do not receive appeal-related information in their preferred language, they may be unable to understand their rights, the outcome of their appeal, or the next steps available to them. This can lead to confusion, missed deadlines, and an inability to make informed decisions about their care—ultimately putting members at risk of harm.

Recommendation: Revise and implement procedures to ensure that all members' correspondence, including acknowledgment and resolution letters, are translated into the member's preferred threshold language before distribution.

DHCS AUDITS AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
RANCHO CUCAMONGA SECTION

**REPORT ON THE MEDICAL AUDIT OF LOCAL
INITIATIVE HEALTH AUTHORITY FOR LOS
ANGELES COUNTY DBA: L.A. CARE HEALTH PLAN
2025**

Contract Number: 23-30264

Contract Type: State Supported Services

Audit Period: February 1, 2024 — September 30, 2025

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TABLE OF CONTENTS

I.	INTRODUCTION	3
II.	COMPLIANCE AUDIT FINDINGS	4

I. INTRODUCTION

This report presents the results of the audit of Local Initiative Health Authority for Los Angeles County, doing business as L.A. Care Health Plan (Plan), compliance and implementation of the State Supported Services contract number 23-30264 with the State of California. The State Supported Services Contract covers abortion services with the Plan.

The audit covered the period of February 1, 2024, through September 30, 2025. The audit was conducted from October 20, 2025, through October 31, 2025, which consisted of a document review and verification study with the Plan administration and staff.

An Exit Conference with the Plan was held on April 9, 2026. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the Exit Conference. The results of the Department of Health Care Services' (DHCS) evaluation of the Plan's response are reflected in this report.

COMPLIANCE AUDIT FINDINGS

State Supported Services

This is a companion to L.A. Care Health Plan's Medi-Cal Managed Care Health Plan Contract 23-30232, hereafter referred to as the "Primary Contract," to cover specific Medi-Cal State-Supported Services to L.A. Care Health Plan's members enrolled under L.A. Care Health Plan's Primary Contract.

The Plan agrees to provide, or arrange to provide, to eligible members enrolled under either this Contract or the Primary Contract, the following Private Services: Current Procedural Terminology codes 59840 through 59857 and Centers for Medicare & Medicaid Services and Common Procedure Coding System codes: X1516, X1518, X7724, X7726, and Z0336. These codes are subject to change upon the DHCS' implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code sets provisions. *(State Supported Services Contract, Exhibit A)*

Minor consent services mean those covered services of a sensitive nature that minors may receive without parental or guardian consent. Under Age 12: Pregnancy and pregnancy-related services, family planning services, and sexual assault services. *(Contract Exhibit A, Attachment I, 1.0 (Definitions))*

The Plan must conduct an annual review of its Provider Manual (PM) and document that the review has been conducted by the appropriate Plan committees, including the Quality Improvement Committee. The Plan must update its PM annually or at any time to ensure that the information reflects current requirements. *(Contract Exhibit A, Attachment III, 3.2.4)*

The Plan must develop, implement, and maintain written policies and procedures that set forth the member's rights and responsibilities and must communicate its policies to its providers. *(Contract Exhibit A, Attachment III, 5.1.1)*

The Plan must ensure access to minor consent services for members. Minor consent services include treatment for the following: Under Age 12: pregnancy and pregnancy-related services, family planning services, and sexual assault services. *(Contract Exhibit A, Attachment III, 5.2.8(D)(1))*

The Plan's *Universal Provider Manual (UPM) Serving Los Angeles County* (reviewed 01/01/2024 and 01/01/2025), states that benefit coverage for members 12 years of age and older may receive any sensitive services without parental consent.

Finding: The Plan did not update its PM to reflect current requirements. These requirements specify that members under age 12 may receive pregnancy-related care, family planning services, and sexual assault services without parental or guardian consent.

The Plan's system for communicating member rights and provider responsibilities relies in part on its PM as a key reference for providers on covered benefits, including minor consent services. The contract requires the PM to be reviewed and updated annually or as needed to reflect current requirements. However, the 2024/2025 PM did not include the required language on minor consent services for members under age 12, resulting in limited guidance for providers.

During the interview, the Plan presented its online 2024/2025 PM, which did not include the required language on minor consent services for members under age 12. As a result, the manual lacked sufficient detail to guide providers on these contractual requirements. The Plan acknowledged that the minor consent language in the PM is deficient.

If Providers are unaware of a member's rights to access certain minor consent services, care may be denied, referrals may be missed, or rights may be violated.

Recommendation: Revise the PM to include explicit language stating that members under age 12 may access minor consent services—pregnancy and pregnancy-related services, family planning services, and sexual assault services—without parental consent. Implement a process to ensure that all future updates to the PM and related materials comply with current legal and contractual requirements for minor consent services.