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

L.A. Care Health Plan

Contract Number: 04-36069 A08

Audit Period: July 1, 2016
Through
June 30, 2017

Report Issued: April 26, 2018

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I. INTRODUCTION

L.A. Care Health Plan (LA Care or the 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. LA Care is Knox-Keene licensed and located in Los Angeles.

L.A. Care provides managed care health services to Medi-Cal beneficiaries under the provision of the Welfare and Institutions Code, Section 14087.3. The Plan is a separately constituted health authority governed by an independent county Board of Supervisors. L.A. Care utilizes a "Plan Partner" model, under which it contracts with three health plans through capitated agreements. The Plan Partners (PPs) are Anthem Blue Cross, Care 1st Health Plan, and Kaiser Permanente. In addition to the Plan Partners model, the Plan began providing coverage directly to Medi-Cal members under its own line of business, Medi-Cal Care Los Angeles (MCLA) in 2006. In its direct line of business, the Plan contracts with 32 Participating Physician Groups (PPGs) who are paid a capitated amount for each enrollee.

As of June 1, 2017, L.A. Care's Medi-Cal enrollment was approximately 2,116,948 members. Enrollment by product line are as follows:

Medi-Cal Members (PP's and MCLA)	2,027,486
Cal MediConnect	14,918
L.A. Covered California	25,463
PASC-SEIU Plan	49,081

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical review audit for the review period of July 1, 2016 through June 30, 2017. The onsite review was conducted from September 18, 2017 through September 29, 2017. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit conference was held on March 13, 2018 with the Plan. 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 audit evaluated six categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Members' Rights, Quality Management (QI), and Administrative and Organizational Capacity.

The summary of the findings by category follows:

Category 1 – Utilization Management

No findings noted during this audit period.

Category 2 – Case Management and Coordination of Care

The Plan lacked involvement in the Behavioral Health Treatment (BHT) comprehensive diagnostic evaluation process to ensure that children with Autism Spectrum Disorder received a diagnosis as early as possible. The Plan had no formal process in place to monitor and ensure access to comprehensive screening and comprehensive diagnostic evaluation initiated in accordance with timely access standards.

The Plan was unable to demonstrate and provide supportive documentation that the treatment plan for BHT was reviewed in compliance with current DHCS All Plan Letter (APL) 15-025 standards.

Category 3 – Access and Availability of Care

The Plan's online PDF Provider Directory dated July 1, 2017 was not up-to-date and accurate. The Plan relied on providers submitting current provider directory information. This ongoing finding was included in the 2016 Corrective Action Plan (CAP). At this time, the Plan is still in the early stages of the implementation process therefore, the effectiveness of the interventions could not be determined.

Category 4 – Member's Rights

The Plan is required to implement and maintain procedures for systemic aggregation and analysis of the grievance and appeal data and use for Quality Improvement. The Plan missed opportunities to refer appeals and grievances for Potential Quality Improvement (PQI) tracking and trending purposes.

Category 5 – Quality Management

No findings noted during this audit period.

Category 6 – Administrative and Organizational Capacity

The Plan lacked policies and procedures to monitor timely reporting of changes in the status of Chief Medical Director to DHCS within 10 calendar days.

The Plan did not report suspected fraud or abuse cases to DHCS within 10 working days.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the DHCS Medical Review Branch (MRB) to ascertain that services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's Two-Plan Contract. This audit focused on MCLA, the Plan's own line of business providing direct coverage to Medi-Cal members.

PROCEDURE

DHCS conducted an on-site audit of L.A. Care from September 18, 2017 through September 29, 2017. The audit included a review of the Plan's contract with DHCS, its policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 20 routine medical and 10 pharmacy prior authorization requests were reviewed for timeliness of decision making, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Prior Authorization Appeal Procedures: 20 appeals were reviewed for appropriateness and timeliness of decision of making.

Category 2 – Case Management and Coordination of Care

Behavioral Health Treatment: 20 medical records were reviewed for completeness.

Category 3 – Access and Availability of Care

Emergency Service Claims: 20 emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: 20 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 20 grievances (10 Quality of Care and 10 Quality of Service), seven Behavioral Health (BHT) grievances, nine exempt grievances (24-hour exemptions), and 20 inquiries were reviewed for timely resolution, response to complainant, and

appropriate medical decision-making. Exempt grievances and inquiries also included mental health and BHT grievances.

No HIPPA cases were reviewed for the audit period under review.

Category 5 – Quality Management

Provider Training: 17 new provider training records were reviewed for timely provision of Medi-Cal Managed Care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse Reporting: 15 cases were reviewed for proper reporting of all suspected fraud or abuse to the appropriate entities within the required timeframes.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.3	BEHAVIORAL HEALTH TREATMENT

Services for Members under Twenty-One (21) Years of Age:
Contractor shall cover and ensure the provision of screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 years of age including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services.
2-Plan Contract A.10.5

ALL PLAN LETTER 15-025: Responsibilities for Behavioral Health Treatment coverage for Children Diagnosed with Autism Spectrum Disorder:
The MCP is responsible for the provision of EPSDT services to include medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavior Analysis (ABA) and other evidence-based behavioral interventions, professional services, and treatment programs to prevent or minimize the adverse effects of Autism Spectrum Disorder (ASD) and to promote to the maximum extent practicable, the functioning of a member with ASD.

The MCP must ensure all children receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. When a screening exam indicates the need for further evaluation of a child's health, the child must be referred for medically necessary diagnosis and treatment without delay.

The MCP is required to:

1) Inform members that EPSDT services are available for members under 21 years of age;
2) Provide access to comprehensive screening and prevention services in accordance with the most current Bright Futures periodicity schedule
3) Provide access to Comprehensive Diagnostic Evaluation (CDE) based upon recommendation of a licensed physician and surgeon or a licensed psychologist for treatment of ASD including all medically necessary services, including but not limited to, BHT services.
4) Ensure appropriate EPSDT services are initiated in accordance with timely access standards as set forth in the contract
5) Ensure coverage criteria for BHT are met.

For individuals diagnosed with ASD who are under the age of three with a rule out or provisional ASD diagnosis, or those diagnosed with an intellectual disability, the MCP must ensure appropriate referrals are made to the Regional Center and Special Education Local Plan Area (SELPA) for Regional Center services and supports and/or special education services respectively.

Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program…for the coordination of CCS services to Members.
2-Plan Contract A.11.9.A, B

Delegation Oversight (APL 15-025):
The MCP must ensure that delegates comply with all applicable state and federal laws and regulations, contract requirements, and DHCS guidance, including APLs for the provision of BHT service.

SUMMARY OF FINDINGS:

2.3.1 Access to Comprehensive Diagnostic Evaluation

All Plan Letter (APL) 15-025: Requires the Plan to provide access to comprehensive diagnostic evaluation based upon a recommendation by a licensed physician and surgeon or a licensed psychologist for treatment of Autism Spectrum Disorder (ASD) including all medically necessary services, including but not limited to Behavioral Health Treatment (BHT) services. This policy further states that the Plan must ensure that appropriate Early and Periodic Screening, Diagnostic Treatment Services (EPSDT) are initiated in accordance with timely access standards as set forth in the contract.

California Code of Regulations, Title 28, Section 1300.67.2.2 Timely Access to Non-Emergency Health Care Services states that Standards for Timely Access to Care indicated that Plan is responsible to establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with clinical appropriateness standard. Non-urgent appointments for primary care: within ten (10) business days of the request for appointment. Non-urgent appointments with specialist physicians: within fifteen (15) business days of the request for appointment.

Policy and Procedure BHS-006: Behavioral Health Treatment for Autism Spectrum Disorder states the Plan shall provide access to comprehensive diagnostic evaluation based upon a recommendation of a licensed physician and surgeon or a licensed psychologist for treatment of ASD including all medically necessary services including but not limited to BHT services. This policy also states that the Plan shall ensure that

appropriate BHT services are initiated in accordance with contractual and regulatory timely access standards.

The Plan does not have a formal process in place to provide a comprehensive diagnostic evaluation to qualified members. The Plan does not have a formal process in place to ensure that access to comprehensive screening and comprehensive diagnostic evaluations are initiated in accordance with timely access standards.

According to the Director of Behavioral Health Operations, the Plan works with seven (7) Regional Centers. The Plan provided a Behavioral Health Treatment Flow Chart, which describes the Plan's BHT process. Plan staff stated that the "Primary Care Physician (PCP) refers the member to the Regional Center," but submits no recommendation to the Plan. The Regional Center initiates, conducts and completes the comprehensive diagnostic evaluation without any communication with the Plan.

The Plan is not involved in the comprehensive diagnostic evaluation process to ensure that children receive a diagnosis as early as possible. Without a formal monitoring process in place, screening examinations that may indicate the need for further comprehensive evaluation of a member's health condition, and appropriate referral for medically necessary treatment may be delayed.

2.3.2 Approval of Behavioral Treatment Plan

All Plan Letter (APL) 15-025: Behavioral Health Treatment (BHT) services are provided under a Behavioral Treatment Plan that has measurable goals over a specific timeline for the specific beneficiary being treated and developed by a qualified autism service provider. BHT services to be provided, observed and directed under an approved behavioral treatment plan. The Behavioral Treatment Plan must have the following: No. 9. Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the beneficiary's progress is measured and reported, transition plan, crisis plan and the individual providers responsible for delivering services; and No. 13. Include exit plan/criteria.

All Plan Letter (APL) 15-025 Covered Services: Medi-Cal covered BHT services must be:
1. Medically necessary as defined by Welfare and Institutions Code Section 14132(v).
2. Delivered in accordance with the beneficiary's MCP approved behavioral treatment plan. Services must be provided and supervised under a Managed Care Plan (MCP)-approved behavioral treatment plan developed by a contracted (or other form of agreement between the MCP and provider) and MCP-credentialed "qualified autism service provider," as defined by H&S Code Section 1374.73(c)(3)…BHT services must be provided under a

behavioral treatment plan that has measurable goals over a specific timeline for the specific beneficiary being treated and developed by a qualified autism service provider. The behavioral treatment plan must be reviewed, revised and/or modified no less than once every six months by a qualified autism service provider.

Policy and Procedure BHS-006: Behavioral Health Treatment for Autism Spectrum Disorder states that BHT services shall be rendered in accordance with the beneficiary's treatment plan. The treatment plan shall follow standards set by the state through APL 15-025.

The Plan lacked a formal process for approval of the treatment plan based on APL 15-025 standards. According to the Director of Behavioral Health Operations, the Plan uses a Progress Report Form that was created by the Regional Center. The Progress Report Form references APL 14-017 standards, rather than current standards.

The Plan was unable to demonstrate and provide documentation to support that the treatment plan was reviewed by the Plan using APL 15-025 Standards. The documents that were provided had notes stating, "Report Reviewed." However, there was no indication as to what report was reviewed, and what standards were used for the review process. The verification study further revealed that there were elements missing in the medical records such as, the Transition Plan, Crisis Plan, and Exit Plan.

Without an effective review process, approval, and monitoring of the behavior treatment plan, the member may not receive proper treatment.

Recommendations:

2.3.1 Develop and maintain a formal process to provide and monitor comprehensive diagnostic evaluation for qualified members and ensure that timely access standards are met.

2.3.2 Develop a formal process to review and approve the Behavioral Health Treatment Plan to meet current APL 15-025 standards.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

Appointment Procedures:
Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.
2-Plan Contract A.9.3.A

Members must be offered appointments within the following timeframes:
3) Non-urgent primary care appointments – within ten (10) business days of request;
4) Appointment with a specialist – within 15 business days of request;
2-Plan Contract A.9.4.B

Prenatal Care:
Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.
2-Plan Contract A.9.3.B

Monitoring of Waiting Times:
Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments…
2-Plan Contract A.9.3.C

SUMMARY OF FINDINGS:

3.1.1 Provider Directory

The Contract states that the Plan shall provide each member with a Provider Directory which includes the name, provider number, address, telephone number of each service location, the hours and days when each facility is open, services and benefits available, including if any non-English languages are spoken, the telephone number to call after normal business hours, and identification of providers who are not accepting new patients. (2-Plan Contract A.13.4.D.4)

Welfare and Institutions Code Section 14182 (c)(2) states managed care health plans shall maintain an updated, accurate, and accessible listing of a provider's ability to accept

new patients and shall make it available to enrollees, at a minimum, by phone, written material, and Internet Web site.

Desktop Procedure PNO-001, Maintaining and Updating Provider Directories, states that the Plan makes Web-based physician and hospital directory information available to members through alternate media which includes a printed directory updated no less than quarterly or more frequently: by telephone; and members can contact the Plan directly to request Provider Directory information. The Plan's Data Services staff conducts an annual review/assessment of the provider directories, which allows the Plan to identify opportunities to improve the accuracy of the information in its directories.

The Plan's online PDF Provider Directory dated July 1, 2017 was not up-to-date. The Plan updates the Provider Directory quarterly. However, the verification study disclosed inaccuracies in the Provider Directory, such as, outdated provider information, provider no longer providing patient care, provider no longer contracted with the group, incorrect categorization, and telephone line no longer in service. The Plan relied on providers submitting current information. The Plan recognized the need to improve their Provider Directory.

This ongoing finding was included in the 2016 Corrective Action Plan (CAP). In an effort to correct this deficiency, the Plan has made changes in their organizational structure, and revised the quality control processes. At this time, the Plan is still in the early stages of the implementation process, therefore the effectiveness of the interventions could not be determined.

Without an accurate Provider Directory, members may experience difficulty and delay in obtaining care.

RECOMMENDATIONS:

3.1.1 Monitor and continue to improve the accuracy of the Provider Directory.

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CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

Member Grievance System and Oversight:
Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c).
2-Plan Contract A.14.1

Contractor shall implement and maintain procedures…to monitor the Member's grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858….(as required by Contract)
2-Plan Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).
2-Plan Contract A.14.3.A

SUMMARY OF FINDINGS:

4.1.1 Referral of Grievances and Appeals for Quality Improvement

The Contract requires the Plan to implement and maintain procedures for systematic aggregation and analysis of the grievance data and use for Quality Improvement (QI). (2-Plan Contract A.14.2.C)

Policy and Procedure AG-008, Complaint Process for Members, and Desktop Procedure AG-008A, Grievance Processes for Members describes that, at any point during a review or investigation of a Grievance, if the Plan Specialist determines that a Potential Quality Improvement (PQI) may exist, the case will be forwarded to the Quality Department.

The Plan has policies and procedures in place to refer any potential quality issues regarding appeals and grievances for quality improvement. The verification study revealed multiple samples suggesting an apparent trend wherein the Plan possibly missed opportunities to refer appeals and grievances for PQI tracking and trending

purposes. This was seen in all the categories selected for the review including Utilization Management (Medical), Behavioral Health Treatment (BHT), and Mental Health services.

Plan staff indicated that there had been delays in improving system procedures due to departmental structure changes that occurred during the audit period. The Plan entered a transition process implementing and utilizing an improved inter-departmental integrated data recording system. The transition period also involved major changes with key personnel in relevant departments. This combination of factors apparently contributed to missed opportunities for improving systemic usage of grievance and appeal data for PQI root cause analysis and overall Quality Improvement. This situation has the potential to limit the QI process with respect to the provision and delivery of medically necessary services to members.

Plan staff indicated their knowledge of this deficiency and have already initiated corrective actions regarding operational issues prior to the audit. The Plan described these efforts and activities demonstrating the resumption of more active focus on their process to carry out policies and procedures in these regards with the ultimate goal of continuing the QI referral process for grievances and appeals.

RECOMMENDATION:

4.1.1 Continue to monitor and follow policies and procedures for the Quality Improvement referral process for grievances and appeals.

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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.1	MEDICAL DIRECTOR AND MEDICAL DECISIONS

Medical Director:
Contractor shall maintain a full time physician as medical director pursuant to Title 22 CCR Section 53857 whose responsibilities shall include, but not be limited to, the following:

A. Ensuring that medical decisions are:
   1) Rendered by qualified medical personnel.
   2) Are not influenced by fiscal or administrative management considerations.
B. Ensuring that the medical care provided meets the standards for acceptable medical care.
C. Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.
D. Developing and implementing medical policy.
E. Resolving grievances related to medical quality of care.
F. Direct involvement in the implementation of Quality Improvement activities.
G. Actively participating in the functioning of the plan grievance procedures.

2-Plan Contract A.1.6

Contractor shall report to DHCS any changes in the status of the medical director within 10 calendar days.
2-Plan Contract A.1.7

Medical Decisions:
Contractor shall ensure that medical decisions, including those by sub-contractors and rendering providers, are not unduly influenced by fiscal and administrative management.
2-Plan Contract A.1.5

SUMMARY OF FINDINGS:

6.1.1 Medical Director Changes

Contractor shall report to DHCS any changes in the status of the medical director within ten (10) calendar days. (2-Plan Contract A.1.7)

The Plan did not report to DHCS the change in status of the medical director as required by the contract. During the onsite, the Plan was unable to produce policies and procedures, nor a process to monitor compliance with this function.

Prior to onsite, the audit team learned that the Plan obtained a new Chief Medical Officer (CMO). When mentioned by the audit team during the onsite, the Plan was unable to provide documentation to confirm the new CMO change was reported to DHCS/MCQMD within the required time frame. The Plan's recollection was that MCQMD was verbally notified "at some point upon new CMO hire." No documentation was provided during the onsite to confirm verbal or written notification. The Plan presented an email communication with MCQMD dated September 25, 2017 stating that an updated organization chart would suffice. Upon discussion, the Plan indicated they will develop a process and procedure to ensure this contract requirement is met.

Failure by the Plan to notify a change in Plan CMO/Medical Director as required by the contract could potentially hinder the oversight function and delivery of services to members.

RECOMMENDATIONS:

6.1.1 Develop and implement policies and procedures to monitor and report timely changes in the Chief Medical Director status to meet contract requirements.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

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6.3	FRAUD AND ABUSE

Fraud and Abuse Reporting
Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse….

1) Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract.
2) Contractor shall provide effective training and education for the compliance officer and all employees.
3) Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines.
4) Fraud and Abuse Reporting—Contractor shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity….
5) Tracking Suspended Providers—Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs….

2-Plan Contract E.2.26.B

SUMMARY OF FINDINGS:

6.3.1 Reporting Suspected Fraud and/or Abuse Cases

The contract requires the Plan to report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the

suspected fraud and/or abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity. (2-Plan Contract E.2.26.B)

Policy and Procedure RAC-032, Detecting, Preventing, and Investigating Fraud, Waste and Abuse and Code of Conduct Violations states that if a State filing is needed, the Special Investigation Unit (SIU) Team Leader will complete and submit an MC609 "Confidential Medi-Cal Complaint Report" to the Program Integrity Unit (PIU) DHCS via secure email within ten (10) working days after L.A. Care becomes aware of and/or is notified of the Fraud and Abuse activity. The policy further states that, "waste incidents are not filed with DHCS unless they rise to Abuse."

Policy and Procedure RAC-016, Collaborative Fraud, Waste, and Abuse Investigations Between Plan Partners and L.A. Care Health Plan states that L.A. Care shall inform the DHCS of allegations of Medi-Cal Fraud and Abuse within ten (10) working days from the date the allegation is reported. The policy further states that L.A. Care shall inform DHCS of the results of the SIU investigation of a Medi-Cal Fraud or Abuse allegation within ten (10) working days from the date the investigation concludes.

The Plan did not submit preliminary reports of potential fraud or abuse to DHCS within 10 working days. The verification study revealed instances where no documentation from the Plan was provided to support whether preliminary reports were completed and forwarded to DHCS within the 10 working day requirement.

The Plan did not have a clear understanding of the reporting requirements. The Plan's Policy and Procedure RAC-016, Collaborative Fraud, Waste, and Abuse Investigations Between Plan Partners was not consistent with the required reporting requirements.

Failure to report potential fraud and abuse cases in a timely manner may potentially affect the quality of service to its members.

RECOMMENDATIONS:

6.3.1 Revise policies and procedures to provide clear and accurate guidelines to comply with the 10 working day requirement.

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DEPARTMENT OF HEALTH CARE SERVICES

L.A. Care Health Plan

Contract Number: 03-75799
State Supported Services

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INTRODUCTION

The audit report presents findings of the L.A. Care Health Plan's (the Plan) compliance and its implementation of the State Supported Services contract with the State of California. The State Supported Services contract covers abortion services for the Plan.

The onsite audit was conducted from September 18, 2017 through September 29, 2017. The audit covered the review period from July 1, 2016 through June 30, 2017 and consisted of the review of documents supplied by the Plan and interviews conducted onsite.

An Exit Conference was held on March 13, 2018 with the Plan. There were no deficiencies found for the review period of the Plan's State Supported Services.

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STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS
Abortion Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services: Current Procedural Coding System Codes*: 59840 through 59857 HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336 *These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract. State Supported Services Contract Exhibit A.1

SUMMARY OF FINDINGS:

Abortion services are sensitive services covered by the Medi-Cal program. The Plan is required to ensure members' ready access these services from in- and –out-of-network providers. In addition, the Plan must provide the pregnancy termination procedures through any qualified provider without requiring prior authorization, except for inpatient abortions.

Similar to other sensitive services, the Plan is required to ensure members' confidentiality. The Plan is also required to monitor and to ensure their delegates comply with contract requirements and all applicable state and federal laws and regulations. As stated in the Plan's policies and procedures, the Participating Physician Groups (PPGs) and contracted providers are to provide, arrange for, or otherwise facilitate family planning services.

The Member Services, and the Plan's website which includes health education, informs members, including minors, of their rights to pregnancy termination services and to receive services outside of their health plan's network without a referral.

The Plan maintains a list of CPT codes for procedures and services which are exempt from prior authorization for the Plan's Claims department to use in auto payment of claims submitted. The Plan's claims system configuration ensures no prior authorization is needed. The billing codes for sensitive services which are exempt from prior authorization include the Current Procedural Terminology (CPT) Codes 59840 through 59857, and Healthcare Common Procedure Coding

System (HCPCS) Codes S0199 (Medical Abortion), S0190 (Mifepristone 200 mg), S0191 (Misoprostol 200 mcg), and A4649.

The Plan provides or arranges to provide eligible members with the required State Supported Services and is in compliance with contract requirements.

RECOMMENDATION:

None