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

REPORT ON THE MEDICAL AUDIT OF

L.A. CARE HEALTH PLAN

Contract Number:	04-36069
Audit Period:	July 1, 2018 Through June 30, 2019
Report Issued:	November 8, 2019

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I. INTRODUCTION

L.A. Care Health Plan (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. The Plan obtained its Knox-Keene license in April 1997.

The Plan provides Managed Care health services to Medi-Cal beneficiaries under the provision of the Welfare and Institutions Code, section 14087.3. The Plan is a separately constituted health authority governed by the Los Angeles County Board of Supervisors. The Plan utilizes a "Plan Partner" model, under which it contracts with three health plans through capitated agreements. The Plan Partners are Anthem Blue Cross, Care 1st Health Plan, and Kaiser Foundation Health Plan. 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 who receive a capitated amount for each enrollee.

As of May 2019, the Plan's total enrollment was approximately 2,161,004 members. The detailed enrollment by product line are as follows: 2,008,968 Medi-Cal (Plan Partners, MCLA, and Seniors and Persons with Disabilities), 16,129 Cal MediConnect, 85,305 L.A. Care Covered California, and 50,602 Homecare Workers Health Care Plan members.

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, 2018 through June 30, 2019. The onsite review was conducted from July 15, 2019 through July 26, 2019. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was held on October 10, 2019. 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 October 24, 2019, the Plan submitted a response after the Exit Conference. The results of our evaluation of the Plan's response are reflected in this report.

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

The prior DHCS medical audit report (for the audit period July 1, 2017 through June 30, 2018) was issued on February 7, 2019. The Plan provided a Corrective Action Plan (CAP) and responses to all documented deficiencies. All findings in the CAP were closed as of May 16, 2019. This audit examined the Plan's compliance with the CAP.

A summary of the findings by category are as follows:

Category 1 – Utilization Management

The Contract requires the Plan to determine and to monitor a prospective delegate's ability to perform subcontracted services. The Plan must oversee and remain accountable for any delegated functions and responsibilities. The Plan's management acknowledged limited awareness of certain key functions shared between many of its delegates and their subcontractors. Some critical downstream activities and business relationships receive less oversight by the Plan.

The Contract requires the Plan to comply with all applicable provisions of federal and state laws. Welfare and Institutions Code, section 14103.6 states California-licensed pharmacists may determine prior authorization for pharmaceutical services. Furthermore, California Business and Professions Code, section 4036 defines "Pharmacist" as a natural person to whom a license has been issued by the board (California Board of Pharmacy). The Plan's and the delegated Pharmacy Benefit Manager's policy and procedures failed to address the need for licensed physician or California-licensed pharmacist in making pharmacy prior authorization decisions. In addition, they had non-California-licensed pharmacists approve, defer, and modify prior authorization requests for Medi-Cal pharmacy services.

The Contract requires the Plan to implement and maintain an appeal process. The *Code of Federal Regulations (CFR), Title 42, section 438.400(b) and All Plan Letter (APL)17-*

006 define an appeal as a review of an adverse benefit determination. The Plan and its delegated Pharmacy Benefit Manager misclassified appeals as prior authorization reviews. The Plan's policy and procedures on pharmacy prior authorization failed to address the proper handling of an appeal or a review of an adverse benefit determination. In addition, the Plan did not ensure that its delegated Pharmacy Benefit Manager handled an appeal or review of an adverse benefit determination properly.

Category 2 – Case Management and Coordination of Care

The Contract requires the Plan to ensure the coordination of services and joint case management between its Primary Care Providers (PCPs), the California Children Services (CCS) specialty providers, and the local CCS program. The Plan did not coordinate or monitor CCS services through case management.

The Contract requires the Plan to cover and ensure the provision of an Initial Health Assessment (IHA) to new members. The IHA shall include an age appropriate DHCS approved Individual Health Education Behavioral Assessment (IHEBA)/Staying Healthy Assessment (SHA). However, the Plan did not administer IHEBA/SHA as part of the IHA.

The Contract requires the Plan to make reasonable attempts to contact a member and schedule an IHA. The Plan shall document all attempts to be considered evidence in meeting this requirement. The Plan's PCPs did not document the attempts to schedule the members' IHAs.

Medi-Cal Managed Care Division (MMCD) Policy Letter 08-003 requires the Plan to complete IHAs for new Plan members who continue to see their existing PCPs from their previous Plans. The Plan did not have policy and procedures to include the requirement. Therefore, the existing PCPs did not have IHA updated nor physical exam performed within 12 months of the members' enrollment.

The Contract requires the Plan to ensure that each member has a PCP. *MMCD Policy Letter 08-003* requires the Plan's PCPs to complete IHAs for new Plan members who were admitted or reside in nursing facilities. The Plan did not complete the members' IHAs because they did not assign PCPs to members residing in Institution for Mental Disease (IMD) facilities.

APL 17-019 requires all Plan's network providers to enroll in the Medi-Cal Program. The Plan did not ensure that all Non-Emergency Medical Transportation (NEMT) providers were enrolled in the Medi-Cal Program.

The Plan did not consistently complete the Physician Certification Statement (PCS) form before providing NEMT services as required by *APL 17-010*.

The Plan is required to notify members about the transition process that will occur at the end of the Continuity of Care (COC) period, and the members' rights to choose a different provider from the Plan's network. The Plan did not provide members complete information

regarding their COC rights.

Category 3 – Access and Availability of Care

The Contract requires the Plan to provide investigational drug services as defined in California Code of Regulations (CCR), Title 22, section 51056.1(b), and document all requirements in CCR, Title 22, section 51303(h). The Plan failed to provide accurate information in the 2018 Member Handbook regarding investigational drug services.

APL 17-019 requires the Plan's network providers to enroll in the Medi-Cal Program. The Plan did not develop and implement a managed care provider screening and enrollment process that meets the requirements of *APL 17-019*. Also, the Plan did not enroll only Medi-Cal Fee-for-Service (FFS) pharmacy providers in the Plan's pharmacy network. As of July 2019, the Plan still had 42 non-Med-Cal FFS pharmacy providers in the Plan's pharmacy network. In addition, the Plan also failed to monitor its delegated Pharmacy Benefit Manager's compliance to requirements for provider screening and enrollment in its annual delegation audit.

The CFR, Title 42, section 438.10(f)(1) requires the Plan to give written notice of termination of a contracted provider within 15 "calendar" days. The Plan did not consistently provide written member notice of termination of a contracted provider within 15 calendar days after receipt or issuance of the termination notice. The Plan also failed to monitor its delegated Pharmacy Benefit Manager's (PBM) compliance to provide the written notice within 15 calendar days. In addition, the Plan did not identify procedures for provider termination and member notification in its policy.

Category 4 – Member's Rights

No findings noted for the audit period.

Category 5 – Quality Management

No findings noted for the audit period.

Category 6 – Administrative and Organizational Capacity

No findings noted for the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The audit was conducted by the DHCS Medical Review Branch, to ascertain that services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's Two-Plan Contract. 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 the Plan from July 15, 2019 through July 26, 2019. 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

Delegation of Utilization Management: 20 medical prior authorization files were reviewed for timeliness, consistent application of Plan's criteria, communication clarity, cultural/linguistic attentiveness, and overall regulatory adherence.

Prior Authorization Review Requirements: 20 medical and 20 pharmacy prior authorization files were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Prior Authorization Appeal Process: 35 appeals were reviewed for appropriateness and timeliness of decision-making.

Category 2 – Case Management and Coordination of Care

California Children's Services: Seven medical records were reviewed for coordination and performance of services.

Initial Health Assessment: 20 medical records were requested, but only 6 medical records were received and reviewed for documentation, timely completion, and fulfillment of all components of IHA requirements.

Complex Case Management: Six medical records were reviewed to evaluate the performance of services.

Behavioral Health Treatment (BHT): 17 medical records were reviewed for coordination, completeness, and compliance with BHT provision requirements.

Non-Emergency Medical Transportation: 20 claims were reviewed to confirm compliance with NEMT requirements.

Non-Medical Transportation (NMT): 20 claims were reviewed to confirm compliance with NMT requirements.

Continuity of Care: 10 files were reviewed for timeliness and appropriateness of COC request determination.

Category 3 – Access and Availability of Care

Appointment Procedures and Monitoring Waiting Times: 25 providers of routine, urgent, specialty, and prenatal care from the Plan's directory were reviewed for available appointment wait-time compliance.

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

Category 4 – Member's Rights

Grievance Procedures: 45 grievances (30 standard, 5 exempt and 10 expedited) were reviewed for timely resolution, response to complainant, and appropriate level of review and medical decision-making.

Confidentiality Rights: 16 Health Insurance Portability and Accountability Act (HIPAA) cases were reviewed for proper reporting of all suspected and actual breaches to the appropriate DHCS individuals within the required timeframe.

Category 5 – Quality Management

New Provider Training: 56 new contracted provider files were reviewed to determine if they received Medi-Cal Managed Care Program training in a timely manner.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse Reporting: 15 cases were reviewed for proper reporting of all suspected fraud and or abuse to DHCS 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 1 - UTILIZATION MANAGEMENT

1.1	DELEGATION OVERSIGHT

1.1.1 Documentation of the Plan's Oversight of its Delegates and Subcontractors

The Contract states, "Plan may enter into Subcontracts with other entities in order to fulfill the obligation of the Contract. Plan shall evaluate the prospective subcontractor's ability to perform the subcontracted services, shall oversee and remain accountable for any functions and responsibilities delegated and shall meet the subcontracting requirements as stated in CFR, 42, 438.230(b)(3), (4) and CCR, Title 22, section 53867."
(Contract, Exhibit A, Attachment 6(14))

The Contract further states that, "To ensure that any agents, including subcontractors but excluding providers of treatment services, to whom Plan provides [Protected Health Information] (PHI) received from or created or received by Plan on behalf of DHCS, agree to the same restrictions and conditions that apply to Plan with respect to such PHI; and to incorporate, when applicable, the relevant provisions of this Contract into each Subcontract or subaward to such agents or subcontractors." (*Contract, Exhibit G (3)(D)*)

APL 17-004 states, "Medi-Cal managed care health care plans (MCPs) are ultimately responsible for ensuring that their subcontractors and delegated entities comply with all applicable state and federal laws and regulations; contract requirements; reporting requirements; and other DHCS guidance including, but not limited to, APLs. MCPs must have in place policies and procedures to communicate these requirements to all subcontractor and delegated entities."

APL 17-004 also states, "Information and data sharing must be conducted in accordance with all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements, and other state and federal statutes and regulations. MCPs must have in place policies and procedures to monitor subcontractor compliance with care coordination requirements and must ensure that care coordination is provided in compliance with the oversight and reporting requirements set forth in their contract with DHCS and all applicable APLs."

Finding: Documentation of the Plan's oversight of its delegates and subcontractors was thoroughly reviewed. During an interview of a Plan delegate, it was discovered that the delegate relies on four separate subcontractors to accomplish various aspects of claims

processing. Once informed, the Plan's management conveyed lack of knowledge of this arrangement. The Plan acknowledged that they do not routinely review contracts between delegates and subcontractors.

The Plan did not allocate sufficient resources to oversee the delegates' subcontracting.

Unless the Plan monitors all of its delegates' critical activities, such as claims processing, members may be adversely affected.

Recommendation: Develop a process to monitor the delegates' subcontracts.

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1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Prior Authorization Requests for Pharmaceutical Services

The Contract requires the Plan and its delegated PBM, to comply with all applicable provisions of federal and state laws. The Contract further states, "Decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease…a qualified physician or Plan's pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services…" (*Contract, Exhibit A, Attachment 5(2)(A) and (B)*)

Medi-Cal Managed Care Division Policy Letter 08-013, defines "qualified pharmacist" and clarifies that a California-licensed pharmacist may approve, defer, modify, approve as modified, or deny prior authorization requests for pharmacy services pursuant to *Health and Safety Code, section 1367.01(c) and (e), Welfare and Institutions Code, section 14103.6 and Business and Professions Code, section 4036*.

Welfare and Institutions Code, section 14103.6 states that prior authorization for pharmaceutical services may be determine by pharmacists licensed by the California Board of Pharmacy. Furthermore, California Business and Professions Code, section 4036 defines "Pharmacist" as a natural person to whom a license has been issued by the board (California Board of Pharmacy).

The Plan's policy and procedures *PHRM-011*, *Prior Authorization* last updated on January 1, 2019, states that "Only a licensed physician or a licensed healthcare professional who is competent to evaluate the specific clinical issues involved…may deny or modify requests for authorization of medical necessity."

The Plan's delegated PBM's policy and procedures on pharmacy prior authorizations, last updated on August 14, 2018, states, "Pharmacists with an active, professional, relevant license in good standing in relevant state of practice (Wisconsin, Arizona, or other state as required)." However, the PBM's policy does not specify California licensure.

Finding: The Plan's and PBM's policies and procedures failed to address the need for licensed physician or California-licensed pharmacist in making pharmacy prior authorization decisions. The verification study revealed that the Plan, through its delegated PBM, had non-California-licensed pharmacists making prior authorization decisions in 17 cases.

The Plan did not comply with the contract requirements and California state laws by having non-California-licensed pharmacists approve, defer, or modify, prior authorization requests for pharmaceutical services for Medi-Cal pharmacy services.

Recommendation: Develop procedures and quality assurance process to ensure that only California licensed pharmacists and other qualified individuals make prior authorization decisions for pharmaceutical services, and that delegate PBM complies with contract requirements and California laws.

1.2.2 Misclassified Appeals as Prior Authorization Re-Reviews

The Contract requires the Plan and its delegated PBM, to comply with all applicable provisions of federal and state laws. The Contract further requires the Plan to "implement and maintain an appeal process." (*Contract, Exhibit A, Attachment 14(5)*)

The Contract further states that, "All Policy Letters issued by DHCS Medi-Cal MMCD subsequent to the effective date of this Contract shall provide clarification of Plans obligations pursuant to this Contract, and may include instructions to the Plans regarding implementation of mandated obligations pursuant to changes in state or federal statues or regulations, or pursuant to judicial interpretation." (*Contract, Exhibit E, Attachment 2(1)(D)*)

According to the *CFR, Title 42, section 438.400(b),* an appeal means a review of an adverse benefit determination. *The MMCD APL 17-006* also defines an appeal as a review of an adverse benefit determination.

The Plan's policy and procedures *PHRM-011, Prior Authorization*, last updated on January 1, 2019, defines "Adverse Benefit Determination: the denial, in whole or in part, of a requested service, including determinations based on type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit." *PHRM-011,* further states, "The Appeal Process…is available for any adverse benefit determination."

Finding: The Plan and its delegated PBM misclassified appeals as prior authorization reviews. The verification study revealed that the Plan, through its delegated PBM, reviewed nine adverse benefit determinations previously issued as prior authorization reviews and failed to classify these "re-reviews" as appeals. As a result, the Plan and its delegated PBM failed to comply with contract requirements.

When the Plan misclassifies appeals as prior authorization reviews, this causes a delay for the members and prescribing providers to exhaust the Plan's internal appeal

process. Consequently, the Plan may delay or deny the members' and prescribing providers' rights to seek external Independent Medical Review and/or State Hearing.

Recommendation: Develop procedures and quality assurance process to ensure proper handling of appeal request or review of an adverse benefit determination, and the delegated PBM complies with the contract requirements.

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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**

2.1.1 California Children Services (CCS)

The Contract states, "Plan shall develop and implement policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program. The policies and procedures…shall ensure that…once eligibility for the CCS program is established for a member, Plan shall continue to provide all Medically Necessary Covered Services that are not authorized by CCS and shall ensure the coordination of services and joint case management between its PCPs, the CCS specialty providers, and the local CCS program." (*Contract, Exhibit A, Attachment 11(9)(A)(5)*)

According to Desktop Procedure *MMUM-068, California Children's Services Program*, states "The Plan will monitor its delegated entities' compliance through analysis of reports and audits/monitoring activities according to the Plan's Clinical Assurance Department for delegation oversight."

Finding: The Plan did not coordinate or monitor CCS services through case management. The verification study review disclosed that seven charts did not have case management notes.

According to the Plan, they did not coordinate and monitor CCS because CCS providers worked directly with CCS and excluded the Plan in the process.

When the Plan does not coordinate and monitor CCS services, members may not receive all medically necessary services.

Recommendation: Implement procedures to ensure CCS are coordinated and monitored.

2.1.2 Screening tools not consistently used as part of Initial Health Assessment (IHA)

The Contract states, "Plan shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with CCR, Title 22, section 53851(b)(1) to each new member within timelines...Plan shall ensure that the IHA includes an Individual Health Education Behavior Assessment (IHEBA) using an age appropriate DHCS approved assessment tool." (*Contract, Exhibit A, Attachment 10(3)(A) and (B)*)

The Plan's policy and procedures *HE-012, Staying Healthy Assessment* (SHA), and Provider Manual cover the notification process, training, SHA schedule, administration, review, and documentation. DHCS-approved SHA forms are available to download from the Plan's website, and may be ordered in large quantities from the Plan. In addition, the Plan offers training on completing the SHA.

Finding: The verification study disclosed that five members did not have IHEBA/SHA administered as part of the IHA.

The Plan did not have an effective system to ensure that all components of the IHA are completed.

When the IHEBA/SHA is not administered as part of the IHA, the PCP may not identify high-risk behaviors, initiate discussion, and counseling to those members.

Recommendation: Develop a process to ensure that PCPs administer the IHEBA/SHA as part of the IHA.

2.1.3 Members not consistently contacted to schedule an IHA

The Contract states, "Plan shall make reasonable attempts to contact a member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Plan's unsuccessful efforts to contact a member and schedule an IHA shall be considered evidence in meeting this requirement." (*Contract, Exhibit A, Attachment 10(3)(D)*)

The Plan's policy and procedures *UM-135, Initial Periodic Health Assessments (IHA)* and the Provider Manual cover documenting reasonable attempts to contact a member to schedule an IHA visit.

Finding: The Plan was required to make reasonable attempts to contact the member to schedule an IHA, but also document those attempts. The verification study disclosed that the Plan did not document any attempts to schedule an IHA for 17 members.

The Plan did not have an effective system to ensure that attempts to call the member and schedule the IHA were documented as requirement by the Contract.

When the Plan or its PCPs do not call members to schedule IHA appointments, this may lead to a delay for members' management and treatment of acute and chronic conditions.

Recommendation: Develop a process to ensure that PCPs document reasonable attempts to contact a member to schedule an IHA.

2.1.4 IHAs not completed for new Plan members with existing PCPs

The Contract states, "All existing final Policy Letters issued by MMCD shall be complied with by Plan. All Policy Letters issued by MMCD subsequent to the effective date of this Contract shall provide clarification of Plan obligations pursuant to this Contract, and may include instructions to the Plan regarding implementation of mandated obligations pursuant to changes in state or federal statutes or regulations, or pursuant to judicial interpretation." (*Contract, Exhibit E, Attachment 2(1)(D)*)

MMCD Policy Letter 08-003 states, "For new plan members who choose their current PCP as their new plan PCP, an IHA still needs to be completed within 120 days of enrollment. The current established PCP may incorporate relevant patient historical information from the member's old chart. However, the PCP must conduct an updated physical exam if the patient has not had a physical exam within 12 months of enrollment."

Finding: The Plan did not have policy and procedures to address the above requirement from the *MMCD Policy Letter 08-003*. The Plan provided six medical records. The verification study revealed that two new Plan members, who chose their existing PCPs did not have IHAs updated. The existing PCPs did not update the members' charts nor performed physical exams within 12 months of the members' Plan enrollments.

The Plan does not have policies and procedures to ensure that an IHA still needs to be completed and updated for new Plan members who choose their existing PCPs.

When the IHA is not completed, the PCPs may not identify any new medical issues of members and this may lead to a delay in the management and treatment of acute and

chronic conditions.

Recommendation: Develop policy and procedures to ensure provision of a comprehensive IHA is completed within 120 days of enrollment to a new Plan member with an existing PCP.

2.1.5 IHAs for members residing in Institutional Facilities

The Contract states, "Plan shall ensure that each member has a PCP who is available and physically present at the service site for sufficient time to ensure access for the assigned member when medically required." (*Contract, Exhibit A, Attachment 9(1)*)

Policy Letter 08-003 states, "An IHA may be performed in settings other than ambulatory care for members who are continuously enrolled for 120 days. For members admitted to a nursing facility, or residing in a nursing facility when they become a Plan member, the nursing facility PCP assessment may provide information for the IHA. However, the Plan PCP must either complete the IHA or ensure completion of all components of the IHA."

Code of Federal Regulations, Title 42, section 435.1010 states, "Institution for mental diseases means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such."

Finding: The verification study disclosed that IHAs were not completed for three members residing in IMD because they were not assigned PCPs. The Plan indicated that there are approximately 400 members residing in IMD.

The Plan did not have a process in place to ensure that IHAs were completed for members residing in IMD, and the Plan had no alternative methods to ensure completion of their IHAs as required by *Policy Letter 08-003*.

When members are not assigned to PCPs, the PCPs may not identify and manage the members' acute and chronic conditions through IHAs.

Recommendation: Develop a process to ensure that each new member has a PCP to administer a comprehensive IHA, as required by *Policy Letter 08-003*.

2.4	NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)/NON-MEDICAL TRANSPORTATION (NMT)

2.4.1 NEMT Providers not Enrolled in Medi-Cal

The Contract states, "All existing final Policy Letters issued by MMCD shall be complied with by Plan. All Policy Letters issued by MMCD subsequent to the effective date of this Contract shall provide clarification of Plans obligations pursuant to this Contract, and may include instructions to the Plan regarding implementation of mandated obligations pursuant to changes in state or federal statutes or regulations, or pursuant to judicial interpretation. In the event DHCS determines that there is an inconsistency between this Contract and a MMCD Policy Letter, the Contract shall prevail." (*Contract, Exhibit E, Attachment 2(1)(D)*)

APL 17-019 Provider Credentialing/Re-credentialing and Screening/Enrollment states, All Medi-Cal MCP network providers must enroll in the Medi-Cal Program. MCPs have the option to develop and implement a managed care provider screening and enrollment process that meets the requirements of this APL, or they may direct their network providers to enroll through DHCS. MCPs electing to establish their own enrollment process are expected to have their infrastructure in place by January 1, 2018. MCPs may screen and enroll network providers in a manner that is substantively equivalent to DHCS' provider enrollment process. However, MCPs may also rely on the enrollment and screening results conducted by DHCS or other MCPs. MCPs can access the California Health and Human Services', Open Data Portal, to obtain a list of currently enrolled Medi-Cal FFS providers. MCPs are required to issue network providers a "verification of enrollment" that MCPs can rely on to prevent enrollment duplication. MCPs may collaborate with each other to share provider screening and enrollment results."

Finding: The Plan failed to ensure that all NEMT providers were enrolled in the Medi-Cal Program as required by *APL 17-019*. The Plan uses a Transportation Vendor to provide NEMT services to Medi-Cal members. Review of the Plan's NEMT paid claims revealed that six providers were not enrolled in the Medi-Cal Program, yet they provided NEMT services to Medi-Cal members. According to the Plan's contract with the Transportation Vendor, the Transportation Vendor is responsible for its own enrollment and screening process for its affiliated providers.

The Plan failed to monitor the Transportation Vendor's enrollment and screening process, to ensure that all NEMT providers were enrolled in the Medi-Cal Program. Without the provider credentialing and screening process, Medi-Cal members can be subject to inadequate and unsafe transportation conditions.

Recommendation: Establish a process to monitor the credentialing, screening, and enrollment of all NEMT providers as required by *APL 17-019*.

2.4.2 PCS Forms not Completed

The Contract states, "All existing final Policy Letters issued by MMCD shall be complied with by Plan. All Policy Letters issued by MMCD subsequent to the effective date of this Contract shall provide clarification of Plans obligations pursuant to this Contract, and may include instructions to the Plan regarding implementation of mandated obligations pursuant to changes in state or federal statutes or regulations, or pursuant to judicial interpretation. In the event DHCS determines that there is an inconsistency between this Contract and a MMCD Policy Letter, the Contract shall prevail." (*Contract, Exhibit E, Attachment 2(1)(D)*)

APL 17-010 states, "MCPs and transportation brokers must use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. Once the member's treating physician prescribes the form of transportation, the MCP cannot modify the authorization."

The Plan's policy and procedures *MMUM-060, Coordinating Non-Emergency Medical Transportation (NEMT) & Non-Medical Transportation (NMT)* states, "Once the member's treating physician prescribes the form of transportation, the Plan will not modify the authorization. NEMT services are a covered Plan benefit when a qualifying member needs to obtain medically necessary covered services and when prescribed in writing by a physician, physician assistant, nurse practitioner, certified midwife, physical therapist, speech therapist, occupational therapist, dentist, podiatrist, or mental health or substance use disorder provider. NEMT services are subject to a prior authorization, except when a member is transferred. A PCS Form must be completed before NEMT can be provided."

Finding: The Plan is required to complete the PCS form before NEMT services can be provided; however, the verification study revealed that 16 NEMT claims had no PCS forms.

The Plan has a policy and procedures that states that the PCS form must be completed before NEMT services can be provided. However, the Plan did not follow their policy and procedures as required by *APL 17-010*.

Without a PCS form or a fully completed PCS form from the treating physician, the member's medical transportation needs may be compromised.

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Recommendation: Implement procedures to ensure that PCS forms are completed before NEMT services are provided.

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2.5	CONTINUITY OF CARE

2.5.1 Continuity of Care Approval Letters

The Contract states, "All existing final Policy Letters issued by MMCD are hereby incorporated into this Contract and shall be complied with by [the] Plan. All Policy Letters issued by MMCD subsequent to the effective date of this Contract shall provide clarification of Plan's obligations pursuant to this Contract, and may include instructions to the Plan regarding implementation of mandated obligations pursuant to changes in state or federal statutes or regulations, or pursuant to judicial interpretation. (*Contract, Exhibit E, Attachment 2(1)(D)*)

APL 18-008 states, "Upon approval of a COC request, the MCP must notify the member of the following within seven calendar days:

- The request approval.
- The duration of the COC arrangement.
- The process that will occur to transition the member's care at the end of the COC period.
- The member's right to choose a different provider from the MCP's provider network."

Finding: The Plan's COC approval letter template did not include information regarding the transition process that will occur at the end of the COC period, and the member's rights to choose a different provider from the Plan's network.

The Plan's COC approval letter did not include all required elements as stated in the *APL 18-008*.

When the member is not informed of the transition process at the end of the COC period or the member's rights to choose a different provider from the Plan's provider network, the member may experience a delay or interruption of medically necessary services.

Recommendation: Update the COC approval letter to include all elements required in *APL 18-008*.

3.4.1 Investigational Services

The Contract states, "Plan shall provide investigational services as defined in CCR, Title 22, section 51056.1(b) when a service is determined to be investigational pursuant to section 51056.1(c), and that all requirements in section 51303(h) are clearly documented." (*Contract, Exhibit A, Attachment 10(9)*)

Specifically per CCR, Title 22, section 51303, "Investigational services are not covered except when it is clearly documented that all of the following apply:

(1) Conventional therapy will not adequately treat the intended patient's condition;
(2) Conventional therapy will not prevent progressive disability or premature death;
(3) The provider of the proposed service has a record of safety and success with it equivalent or superior to that of other providers of the investigational service;
(4) The investigational service is the lowest cost item or service that meets the patient's medical needs and is less costly than all conventional alternatives;
(5) The service is not being performed as a part of a research study protocol;
(6) There is a reasonable expectation that the investigational service will significantly prolong the intended patient's life or will maintain or restore a range of physical and social function suited to activities of daily living."

The regulation does not restrict investigational services to only terminal illness.

The Plan's policy and *procedures MMUM-027, Evaluation and Review of Experimental, Investigational & Unproven Therapies & Independent Medical Review (IMR) & Clinical Trials*, last updated on July 12, 2019, addresses the coverage of investigational drug services pursuant to Contract requirements and CCR, Title 22, sections 51056.1 and 51303.

However, the Plan's 2018 Member Handbook states drugs that are experimental or investigational in nature are not covered, except in certain cases of terminal illness.

Finding: The Plan failed to provide accurate information in the 2018 Member Handbook regarding investigational "drug" services, which is not part of the Evidence of Coverage or Member Handbook template. Therefore, the Plan failed to meet Contract requirements and applicable state regulations.

By failing to provide accurate benefits information in the Plan's Member Handbook, the Plan may adversely affect member services.

Recommendation: Update the Member Handbook to reflect the proper provision of investigational services.

3.4.2 Provider Screening and Enrollment

The Contract states "All Policy Letters issued by MMCD subsequent to the effective date of this Contract shall provide clarification of Plans' obligations pursuant to this Contract, and may include instructions to the Plan regarding implementation of mandated obligations pursuant to changes in state or federal statues or regulations, or pursuant to judicial interpretation." (*Contract, Exhibit E, Attachment 2(1)(D)*).

APL 17-019, regarding Provider Credentialing/Recredentialing and Screening/Enrollment further states "All MCP network providers must enroll in the Medi-Cal Program. MCP's have the option to develop and implement a manage care provider screening and enrollment process that meets the requirements of this APL, or they may direct their network providers to enroll through DHCS. MCPs electing to establish their own enrollment process are expected to have their infrastructure in place by January 1, 2018."

Finding: The Plan's policy and procedures *PHRM-044, Pharmacy Network*, last updated on February 22, 2018, failed to address the requirements set forth in *APL 17-019*. During the onsite interview, the Plan admitted that, through its delegated PBM, it did not develop and implement a Managed Care provider screening and enrollment process that meets the requirements of *APL 17-019*. The Plan also did not enroll only Medi-Cal FFS pharmacy providers in the Plan's pharmacy network. As of July 2019, the Plan still had 42 non-Med-Cal FFS pharmacy providers in the Plan's pharmacy network. In addition, the Plan also failed to monitor its delegated PBM's compliance to requirements for provider screening and enrollment in its annual delegation audit.

The Plan failed to comply with the requirements in *APL 17-019* regarding Provider Screening/Enrollment.

Recommendation: Develop and implement a provider screening and enrollment process that meets the requirements of *APL 17-019*. Develop a quality assurance process to ensure the delegated PBM complies with Contract requirements and *APL 17-019*.

3.4.3 Member Notification of Provider Termination

The Contract states, "Pursuant to Code of Federal Regulations, title 42, section 438.10(f)(5) Plan shall make a good faith effort to give written notice of termination of a contracted provider within 15 days after receipt of issuance of the termination notice to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider." (*Contract, Exhibit A, Attachment 13(5)(B)*)

Pursuant to Code of Federal Regulations, title 42, section 438.2 provider means "any individual or entity that is engaged in the delivery of services or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services." In addition, primary care means "all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing or those services is legally authorized in the State in which the practitioner furnishes them." Therefore, the specific federal requirement applies to pharmacy providers as well.

The Contract also states, "Any provision of this Contract which is in conflict with current or future applicable federal or state laws or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the Contract shall be effective on the effective date of the statutes or regulations necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties." (*Contract, Exhibit E, Attachment 2(1)(B)*)

After the Contract was signed, Federal Register, Vol 81, No. 88 (FR #27853) re-designated section 438.10(f)(5) into section 438.10(f)(1) and added the word 15 "calendar" days for added clarification on May 6, 2016, with an effective date of July 5, 2016. Therefore, the Plan shall comply with amended section 438.10(f)(1).

The Plan's policy and procedures *PHRM-044, Pharmacy Network*, last updated on February 22, 2018, failed to identify procedures for pharmacy suspensions or terminations, and written member notice of termination of a contracted provider within 15 calendar days after receipt or issuance of the termination notice.

Per impact analysis provided by the Plan, 28.3 percent of all member notifications on pharmacy termination were untimely or exceeding 15 calendar days after receipt or issuance of the termination notice.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: July 1, 2018 through June 30, 2019
DATE OF AUDIT: July 15, 2019 through July 26, 2019

Finding: The Plan failed to identify procedures for provider termination and member notification in its policy. The Plan also failed to monitor its delegated PBM's compliance to provider terminations and timely written member notification in its annual delegation audit.

The Plan's failure to provide timely member notification on pharmacy termination may adversely affect member services.

Recommendation: Update the Plan's policy to identify procedures for pharmacy provider termination and member written notice of termination of a contracted provider as required by the contract requirement and amended regulation. Develop a quality assurance process to ensure the delegated PBM complies with contract requirements and amended regulation.

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

REPORT ON THE MEDICAL AUDIT OF

L.A. Care Health Plan

Contract Number:	03-75799 State Supported Services
Audit Period:	July 1, 2018 Through June 30, 2019
Report Issued:	November 8, 2019

TABLE OF CONTENTS

I. 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 July 15, 2019 through July 26, 2019. The audit covered the review period from July 1, 2018 through June 30, 2019 and consisted of the review of documents supplied by the Plan and interviews conducted onsite.

An Exit Conference with the Plan was held on October 10, 2019. The Plan's State Supported Services had no deficiencies noted for the review period.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: L.A. Care Health Plan

AUDIT PERIOD: July 1, 2018 through June 30, 2019
DATE OF AUDIT: July 15, 2019 through July 26, 2019

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:

The Contract requires the Plan to provide eligible members the following State Supported Services: Current Procedural Terminology (CPT) Codes 59840 through 59857, and Healthcare Common Procedure Coding System (HCPCS) Codes S0199 (Medical Abortion), S0190 (Mifepristone 200 mg), and S0191 (Misoprostol 200 mcg).

Abortion services are sensitive services covered by the Medi-Cal program. The Plan is required to ensure that members have access to these services from in-or-out of network providers. The Plan must also 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 ensure t heir delegates comply with all applicable state and federal laws and regulations. As stated in the Plan's policies and procedures, the Participating Physician Groups and contracted providers are to provide, arrange for, or otherwise facilitate family planning services.

The Member Handbook and the Plan's website 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. These services include emergency or urgent services, family planning including outpatient abortions, as well as diagnosis and treatment for sexually transmitted disease services. The Plan maintains a list of CPT codes for procedures and services exempt from prior

authorization for the Plan's Claims Department to use in auto payment of claims submitted. The billing codes for sensitive services exempt from prior authorization listed above as mentioned in CPT and HCPCS.

There were no deficiencies noted during the audit period.

RECOMMENDATIONS:

None