DEPARTMENT OF
Managed
Health Care

Edmund G. Brown Jr., Governor
State of California
Business, Transportation and Housing Agency

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November 28, 2011

via FedEx Delivery and eFile

Dr. James Gerson, Acting CEO, Chairperson of the Board
COUNTY OF LOS ANGELES-DEPARTMENT OF HEALTH SERVICES
Dba Community Health Plan
1000 S. Fremont Ave., Bldg A-9, E. 2nd Floor, U4
Alhambra, CA 91803

FINAL REPORT OF ROUTINE EXAMINATION OF COUNTY OF LOS ANGELES-DEPARTMENT OF HEALTH SERVICES

Dear Dr. Gerson:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of County of Los Angeles-Department of Health Services (the "Plan"), conducted by the Department of Managed Health Care (the Department"), pursuant to Section 1382(a) of the Knox-Keene Health Care Service Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on August 25, 2011. The Department accepted the Plan's electronically filed response on October 7, 2011

This Final Report includes a description of the compliance efforts included in the Plan's October 7, 2011 response, in accordance with Section 1382(c).

Section 1382(d) states "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and electronically file modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within ten (10) days from the date of the Plan's receipt of this letter whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended, and electronically file copies of those portions of the Plan's response excluding information held confidential pursuant to Section 1382(c).

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

If the Plan requests the Department to append a brief statement summarizing the Plan's response to the report or wishes to modify any information provided to the Department in its October 7, 2011 response, please provide the electronically filed documentation no later than ten (10) days from the date of the Plan's receipt of this letter through the eFiling web portal. Please file this addendum electronically via the Department's eFiling web portal https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "File Documents".
- From the File Documents Menu for:
  1) File Type; select "Amendment to prior filing";
  2) Original Filing, select the "Filing No. 20110318" assigned by the Department; and
  3) Click "create filing".
- From the Original Filing Details Menu, click "Upload Amendments"; select # of documents; select document type: "Plan addendum response to Final Report (FE5)"; then "Select File" and click "Upload".
- Upload all documents, and then upload a cover letter as Exhibit E-1 that references to your response.
- After upload is complete, select "Complete Amendment", complete "Execution" and then click "complete filing".

As noted in the attached Final Report, the Plan's response of October 7, 2011 did not fully respond to the deficiencies raised in the Preliminary Report issued by the Department on August 25, 2011**.** Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any request for additional corrective action contained within the attached Final Report, within 30 days after receipt of the report. If the Plan fails to fully respond and/or resolve the deficiencies addressed in the Final Report, then a referral will be made to the Office of Enforcement for appropriate administrative action for any remaining, unresolved deficiencies.

Please file the Plan's response electronically via the Department's eFiling web portal https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "File Documents".
- From the File Documents Menu for:
  1) File Type; select "Amendment to prior filing";
  2) Original Filing, select the "Filing No. 20110318" assigned by the Department; and
  3) Click "create filing".
- From the Original Filing Details Menu, click "Upload Amendments"; select # of documents; select document type: "Plan's Response to Final Report (FE10)",; then "Select File" and click "Upload".
- Upload all documents, and then upload a cover letter as Exhibit E-1 that references to your response.
- After upload is complete, select "Complete Amendment", complete "Execution" and then click "complete filing".

Questions or problems related to the electronic transmission of the above responses should be directed to Rita Ultreras at (916) 322-5393 or email at rultreras@dmhc.ca.gov. You may also email inquiries to wpso@dmhc.ca.gov.

The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter through the eFiling system. The report will be located at the Department's web site at www.dmhc.ca.gov.

If there are any questions regarding this report, please contact me.

Sincerely,

ORIGINAL SIGNED BY

JOAN LARSEN
Supervising Examiner
Office of Health Plan Oversight
Division of Financial Oversight

Cc: Rodgers Moody, Chief Financial Officer, County of Los Angeles
Jie Chen, Audit & Financial Compliance Unit, County of Los Angeles
Suzanne Goodwin-Stenberg, Chief, Division of Financial Oversight
Stephen Babich, Supervising Examiner, Division of Financial Oversight
Maria Marquez, Senior Examiner, Division of Financial Oversight
Tracy Chen, Monitoring Examiner, Division of Financial Oversight
Melissa Borrelli, Staff Counsel, Division of Licensing, Health Plan Oversight
Marcy Gallagher, Chief, Division of Plan Surveys

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

DIVISION OF FINANCIAL OVERSIGHT

COUNTY OF LOS ANGELES- DEPARTMENT OF HEALTH SERVICES

FILE NO. 933-0248

DATE OF FINAL REPORT: NOVEMBER 28, 2011

SUPERVISING EXAMINER: JOAN LARSEN

EXAMINER-IN-CHARGE: MARIA E. MARQUEZ

FINANCIAL EXAMINERS: THOMAS ROEDL,

SUSAN MILLER, SUHAG PATEL and HUGO LOPEZ

BACKGROUND INFORMATION FOR COUNTY OF LOS ANGELES-DEPARTMENT OF HEALTH SERVICES

Date Plan Licensed:	December 30, 1985
Organizational Structure:	The Plan is the Medi-Cal health maintenance organization owned and operated by the County of Los Angeles-Department of Health Services.
Type of Plan:	Full service health care plan that arranges for the provision of health care services under an agreement with the Local Initiative Health Authority for the County of Los Angeles. The Plan also participates in the Medi-Cal Managed Care and Healthy Families Program under a service agreement with the State of California, and the Personal Assistance Services Council-Service Employees International Union Homecare Workers Health Care Plan (In-Home Supportive Services Workers or IHSS).
Provider Network:	The Plan contracts with various medical groups to provide primary professional care to its members on a capitated, or fixed per member per month fee basis. The Plan also contracts with certain hospitals to provide hospital care on a capitation basis. The Plan also pays specialty, hospital and other non-capitated services on a fee-for-service basis.
Plan Enrollment:	As of December 31, 2010, the Plan had 205,210 enrollees, including 153,472 Medi-Cal enrollees, 14,461 Healthy Families members and 37,277 IHSS/TMP enrollees.
Service Area:	Los Angeles County
Date of last Final Report of Routine Examination:	May 16, 2008

FINAL REPORT OF A ROUTINE EXAMINATION OF COUNTY OF LOS ANGELES-DEPARTMENT OF HEALTH SERVICES

This is the Final Report of a routine examination of the fiscal and administrative affairs of County of Los Angeles-Department of Health Services (the "Plan"), conducted by the Department of Managed Health Care (the "Department" or "DMHC") pursuant to Section 1382(a) of the Knox-Keene Health Care Service Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on August 25, 2011. The Department accepted the Plan's electronically filed response on October 7, 2011.

This Final Report includes a description of the compliance efforts included in the Plan's October 7, 2011 response to the Preliminary Report, in accordance with Section 1382(c). The Plan's response is noted in *italics*.

We examined the financial report filed with the Department for the quarter ended December 31, 2010, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions. Our findings are presented in this report as follows:

Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any requests for additional corrective action contained within this report, within 30 days after receipt of this report.

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

SECTION I. FINANCIAL REPORT

A. BALANCE SHEET AT QUARTER ENDED DECEMBER 31, 2010

ASSETS	Bal. per F/S @	AJE or	Exam Adjustments		Bal. per Exam @
Account	**12/31/2010**	**RJE**	**Dr**	**Cr**	**12/31/2010**
Cash and Cash Equivalents	22,251,645				22,251,645
Short-Term Investments					
Premiums Receivable – Net	22,619,187	RJE-1		1,651,775	20,967,412
Interest Receivable	93,669				93,669
Shared Risk Receivables – Net					
Other Health Care Receivables-Net	16,629,905	RJE-1	1,651,775		18,281,680
Prepaid Expenses	1,732,769				1,732,769
Secured Affiliate Receivables – Current					
Unsecured Affiliate Receivables – Current					
Aggregate Write-ins for Current Assets	1,344,764				1,344,764
TOTAL CURRENT ASSETS	**$64,671,939**				**$64,671,939**
Restricted Assets	303,504				303,504
Long-Term Investments					
Intangible Assets & Goodwill- Net					
Secured Affiliate Receivables - Long-Term					
Unsecured Affiliate Receivables - Past Due					
Aggregate Write-ins for Other Assets					
TOTAL OTHER ASSETS	$303,504				$303,504
Land, Building and Improvements					
Furniture and Equipment – Net					
Computer Equipment – Net					
Leasehold Improvements – Net					
Construction in Progress					
Software Development Costs					
Aggregate Write-ins for Other Equipment					
TOTAL PROP & EQUIP					
TOTAL ASSETS	**$64,975,443**		**1,651,775**	**1,651,775**	**$64,975,443**

BALANCE SHEET (Continued)

LIABILITIES **Account**	**Bal. per F/S @ 12/31/2010**	**AJE or RJE**	**Exam Adjustments Dr**	**Exam Adjustments Cr**	**Bal. per Exam @ 12/31/2010**
Trade Accounts Payable	3,854,028				3,854,028
Capitation Payable	18,704,125				18,704,125
Claims Payable (Reported)	2,780,376				2,780,376
Incurred But Not Reported Claims	9,611,255				9,611,255
POS Claims Payable (Reported)					
POS Incurred But Not Reported Claims					
Other Medical Liability	97,311				97,311
Unearned Premiums					
Loans & Notes Payable					
Amounts Due to Affiliates – Current	11,714,116				11,714,116
Aggregate Write-ins for Current Liabilities	3,699,420				3,699,420
TOTAL CURRENT LIABILITIES	**$50,460,631**				**$50,460,631**
Loans and Notes Payable (Not Subordinated)					
Loans and Notes Payable (Subordinated)					
Accrued Subordinated Interest Payable					
Amounts Due To Affiliates - Long Term					
Aggregate Write-Ins for Other Liabilities	4,309,367				4,309,367
TOTAL OTHER LIABILITIES	4,309,367				4,309,367
TOTAL LIABILITIES	**$54,769,998**				**$54,769,998**
NET WORTH					
Common Stock					
Preferred Stock					
Paid in Surplus					
Contributed Capital					
Retained Earnings (Deficit)/Fund Balance	10,205,445				10,205,445
Aggregate Write-ins for Other Net Worth Items					
EXAMINATION ADJUSTMENTS (from Income Statement)					
TOTAL NET WORTH	**$10,205,445**				**$10,205,445**
TOTAL LIAB & NET WORTH	**$64,975,443**				**$64,975,443**

B. STATEMENT OF INCOME AND EXPENSES FOR THE QUARTER ENDED DECEMBER 31, 2010

Account	Bal. Per F/S @ 12/31/2010	AJE or RJE	Exam Adjustments Dr	Exam Adjustments Cr	Bal. per Exam @ 12/31/2010
REVENUES:					
Premiums (Commercial)					
Capitation					
Co-payments, COB, Subrogation					
Title XVIII – Medicare					
Medicaid, Healthy Families	75,705,887				75,705,887
Fee-For-Service					
Point-Of-Service (POS)					
Interest	109,883				109,883
Risk Pool Revenue					
Aggregate Write-Ins for Other Revenues	429,236				429,236
TOTAL REVENUES	**76,245,006**				**$76,245,006**
EXPENSES:					24,101,098
Inpatient Services – Capitated	24,101,098				
Inpatient Services - Per Diem/Managed Hospital					
Inpatient Services - Fee-For-Service/Case Rate					
Primary Professional Services – Capitated	29,914,518				29,914,518
Primary Professional Services - Non-Capitated					
Other Medical Professional Services – Capitated	514,799				514,799
Other Medical Professional Services - Non-Capitated	22,454				22,454
Non-Contracted Emergency Room and Out-of-Area Expense, not including POS	4,989,211				4,989,211
POS Out-Of-Network Expense					
Pharmacy Expense – Capitated					
Pharmacy Expense – Fee-for-Service	5,786,766				5,786,766
Aggregate Write-Ins for Other Capitated Medical and Hospital Expenses					
Aggregate Write-Ins for Other Non-capitated Medical and Hospital Expenses	2,917,568				2,917,568
TOTAL MEDICAL AND HOSPITAL EXPENSES	**68,246,414**				**$68,249,414**
Compensation	3,588,033				3,588,033
Interest Expense					
Occupancy, Depreciation and Amortization					
Management Fees					
Marketing					
Affiliate Administration Services					
Aggregate Write-Ins for Other Administration	3,474,450				3,474,450
TOTAL ADMINISTRATION EXPENSES	**7,062,483**				**$7,062,483**
TOTAL EXPENSES	**75,308,897**				**$75,308,897**
INCOME (LOSS)	**936,109**				$936,109
Extraordinary Item					0
Provision for Taxes					0
NET INCOME (LOSS)	**$ 936,109**				**$936,109**

C. EXPLANATION OF EXAMINATION ADJUSTMENTS

RECLASSIFICATION JOURNAL ENTRY

RJE No.	ACCOUNT NAME	DR	CR
RJE-1	Other Health Care Receivables Premiums Receivable *To properly record QIF Receivable as of December 31, 2010.*	$1,651,775	$1,651,775

The Preliminary Report required the Plan to provide written assurance that the above reclassification journal entry was posted to the books and records and/or provide an explanation regarding the disposition.

The Plan stated it agrees with and acknowledged the deficiency finding regarding the reclassification of Quality Improvement Funding (QIF) receivable. The Plan represented that it took immediate action, effective April 1, 2011, and reclassified the QIF receivable from Premium Receivable to other Health Care Receivable account in the Plan's internal general ledger accounting system – QuickBooks. This change will also be reflected on the DMHC quarterly financial report as of September 30, 2011.

The Plan identified the Chief Financial Officer and the General Accounting Supervisor as the management positions responsible for monitoring the continued compliance.

The Department finds that the Plan's compliance effort is responsive to the corrective action required.

SECTION II. CALCULATION OF TANGIBLE NET EQUITY ("TNE")

Net Worth and TNE per examination as of Quarter Ended December 31, 2010	$ 10,205,445
Required TNE	4,437,154
TNE Excess per Examination	$ 5,768,291

The Plan is in compliance with the TNE requirement of Section 1376 and Rule 1300.76 as of December 31, 2010.

No response required to this Section.

SECTION III. COMPLIANCE ISSUES

A. CLAIM SETTLEMENT PRACTICE – "UNFAIR PAYMENT PATTERN"

Rule 1300.71(a)(8) defines a "demonstrable and unjust payment pattern" or "unfair payment pattern" as any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims.

The Department's examination found that the Plan is engaging in "unfair payment patterns" as summarized in the following table:

Deficiency	Type of Sample	Total in the Sample Population	Total Reviewed	Number of Deficiencies Found	% of Compliance with the Act or Rule
Failure to reimburse claims accurately, including interest and penalty. *Repeat Deficiency*	Late Paid Claims	172	87	59	32%
Medical records requested that were not reasonably relevant.	Late Paid Claims	172	87	48	45%

The following details the unfair payment practices by the Plan found during the Department's examination:

1. CLAIM PAYMENT ACCURACY – *Repeat Deficiency*

Rule 1300.71(a)(8)(K) describes one unfair payment pattern as the failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

Section 1371 requires a health care service plan to reimburse uncontested claims no later than 45 working days after receipt of the claim. This section also requires that if an uncontested claim is not reimbursed within 45 working days after receipt, interest will accrue at the rate of 15 percent per annum beginning with the first calendar day after the 45 working day period.

Section 1371 and Rule 1300.71(j) requires that all interest that has accrued to be automatically included in the claim payment. The penalty for failure to comply with this requirement shall be a fee of ten ($10) dollars paid to the claimant.

Section 1371.35, which refers to claims for emergency services, requires that if an uncontested claim is not reimbursed within 45 working days after receipt by a health care service plan, the plan must pay the greater of $15 per year or interest at the rate of 15 percent per annum, beginning with the first calendar day after the 45 working-day period.

Rule 1300.71(i)(1) requires that late payments on complete claims for emergency services that are neither contested nor denied, shall automatically include the greater of

$15 for each 12-month period or portion thereof on a *non-prorated basis,* or interest at the rate of 15% per annum for the period of time that the payment is late.

The examination found that 59 out of 87 (a non-compliance rate of 68%) late paid claims were not paid interest correctly. Examples are claim samples LP-2, LP-10, LP-22, LP-27, LP-30, LP-57, LP-64, LP-77, LP-85 and LP-97.

This repeat violation was referred to the Office of Enforcement for appropriate administrative action.

The Preliminary Report required the Plan to explain why the corrective actions it implemented to resolve this deficiency in the May 16, 2008 report were not effective in ensuring ongoing compliance.

The Plan was required to submit a Corrective Action Plan ("CAP") to bring the Plan into compliance with the above Sections and Rules that should include, but not be limited to, the following:

a. Identification of all late claims, processed from July 1, 2007 (date after last examination period) through the date corrective action was implemented by the Plan, where interest was not paid or underpaid.

b. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in paragraph "a" above. This evidence is to include an electronic data file/schedule (Excel or dBase) that identifies the following:

    - Claim number
    - Date of service
    - Date original claim received
    - Total billed
    - Total paid
    - Paid date
    - Interest amount paid
    - Date interest paid
    - Penalty amount paid
    - Additional Interest amount paid, if applicable
    - Date additional interest paid if applicable
    - Check Number for additional interest and penalty paid amount
    - Provider name
    - Line of Business
    - ER or Non-ER indicator
    - Number of Late Days used to calculate interest

    The data file is to provide the detail of all claims remediated; and, to include the total number of claims and the total additional interest and penalty paid, as a result of remediation.

c. Policies and procedures implemented to ensure that interest on claims is paid in compliance with the above Section and Rules.

d. Date the revised procedures were implemented, the management position(s) responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

If the Plan was not able to complete the CAP or portions of the CAP within 45 days from receipt of this report, the Plan was required to submit with its response a timeline for completion that does not exceed 180 days from the receipt of this report. If the Plan is not able to meet the 45-day timeframe, then it must justify the reason for the delay and it is required to submit monthly status reports until the CAP is completed.

The Plan stated it agrees with and acknowledged the deficiency finding regarding Claim Payment Accuracy pertaining to interest payment.

The Plan responded that the deficiency on the Claim Payment Accuracy was primarily caused by inpatient ancillary claims which were considered to be unclean due to the lack of inpatient authorization and medical records. The Plan stated this is a uniquely different core reason for the deficiency as compared to the previous root causes associated with the prior deficiency as noted in the May 16, 2008 report.

Effective September 1, 2011, the Plan represented it revised its current policy & procedure on Interest Payment Calculation to include guidelines in determining interest payment for claims that were considered "unclean" due to additional information/medical records requests. The Plan already had an established monitoring and reporting on all Late Paid Claims, which will now be enhanced to have a separate report for those claims which were processed with a request for medical records (comment code 9, 18-29, 54) to ensure that interest and penalties are applied, as appropriate.

The Plan stated it will identify all late paid claims processed from July 1, 2007 through September 1, 2011 and provide the Department an electronic (excel) monthly progress and summary report on claims that were retroactively paid with interest and penalties. The Plan's timeline for completion is within the 180 days from August 25, 2011.

In reference to the effectiveness of the corrective action plan implemented during the 2006/2007 audit on Payment Accuracy; the Plan stated that this issue was caused by the Medi-Cal Fee Schedule discrepancy from the Department of Health Care Services' (DHCS) website and the rate file that CHP purchased from Electronic Data Systems (EDS), DHCS' intermediary. The Plan has been effective in resolving and monitoring the deficiency to date. However, as mentioned above, the Plan stated that the deficiency cited in the 2010 examination has no correlation and is not applicable to the corrective action plan previously implemented.

The Plan's response included as Attachment I the Plan's Revised Policy & Procedure on Interest Payment Calculation.

The Plan identified the Chief Financial Officer and the Claims Manager as the management positions responsible for monitoring and complying with the stated requirements.

The Department finds that the Plan's compliance efforts are not fully responsive to the corrective action required, because the CAP was not completed.

The Department acknowledges that the Plan intends to identify all late paid claims and provide the Department with monthly progress and summary report on claims that were retroactively paid with interest and penalties within 180 days from August 25, 2011. However, the Plan did not submit a justification for not meeting the 45-day timeframe.

The Plan is required to submit the monthly progress and summary reports within 15 days following the close of each month. The first status report will be for the months ended October 31, 2011 and November 30, 2011 and it is due December 15, 2011. These monthly progress reports are to continue to be filed until the CAP is completed by February 28, 2012. The final report is required to include the detail of all claims remediated, the total number of claims, and the total interest and penalty paid, as a result of the remediation.

The monthly status reports are to be submitted through the Department's eFiling web portal as a response to the Final Report.

The Department reviewed the Plan's revised policy and procedure for interest payment in Attachment 1 of the Plan's response and provides the following comments that require corrective action:

- **Section 4.0 Standard Operating Procedure; 4.1: The Plan provides in the last situation of this matrix that "A contract negotiation is concluded and the payer must make retroactive adjustments to previously paid claims; however, the original contract was an "evergreen" contract and the settlement and the contract do not call for interest on the adjustments."**

  The Plan needs to clarify this language for the following: a) if the contract has a fixed settlement amount stated, then no interest is due; and, b) if the contract is silent about any settlement amount then interest is to be paid per claim in accordance with Act and the Rules. The Plan also needs to ensure that the language in the provider contract complies with Section 1371.35(h) and Rule 1300.71(p).

- **Section 4.3: interest calculation needs to include formula for calculating interest on emergency claims [refer to Rule 1300.71(i)(1)]**

2. REQUEST FOR MEDICAL RECORDS

Rule 1300.71(a)(8)(H) describes an unfair payment pattern as the requesting of medical records not reasonably relevant to the adjudication of claims more frequently than in three percent (3%) of the paid claims over any 12-month period to determine payer liability. The calculation of the 3% threshold and the limitation on requests for medical records does not apply to those claims involving emergency or unauthorized services or those cases where the plan has reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices.

The examination found that the Plan requested medical records not reasonably necessary to adjudicate claims in 48 out of 87 (a non-compliance rate of 55%) late paid claims over the three month period ended December 31, 2010. Examples are claim samples LP-5, LP-12, LP-27, LP-46, LP-54, LP-85 and LP-95.

The examination found that claims from an ancillary provider submitted all relevant documentation in their possession with the original claim at the time of receipt by the Plan. The claim payment should not be delayed for hospital records, as the ancillary provider does not have access to these records.

This violation was referred to the Office of Enforcement for appropriate administrative action.

The Preliminary Report required the Plan to implement policies and procedures to ensure that it only requests medical records reasonably relevant for the adjudication of claims in compliance with Rule 1300.71(a)(8)(H). The Plan was also required to provide the date of implementation, the management position(s) responsible for compliance, and a description of the monitoring system implemented to ensure continued compliance with this Rule.

The Plan stated it agrees with and acknowledges the deficiency finding regarding the Request for Medical Records.

Effective September 1, 2011, the Plan represented it implemented a policy and procedure to ensure that it only requests medical records that are reasonably relevant for the adjudication of the claims. The Plan stated it will generate a quarterly report, listing the appropriate medical records request comment codes, and perform a random selection of medical records requests for validation of appropriateness. This random selection will consist of at least 10% of the total claims processed with the medical records request comment codes.

The Plan's response included as Attachment II for the Plan's Policy & Procedure for Request for Medical Records Review.

The Plan identified the Chief Financial Officer and the Claims Manager as the management positions responsible for monitoring and complying with the stated requirements.

The Department finds that the Plan's compliance effort is responsive to the corrective action required.

3. RESCISSION OR MODIFICATION OF AUTHORIZATION

Section 1371.8 states that a health care service plan that authorizes a specific type of treatment by a provider shall not rescind or modify this authorization after the provider renders the service in good faith. Rule 1300.71(a)(8)(T) states the attempt to rescind or modify an authorization after the provider renders the service in good faith on three (3) or more occasions over the course of any three-month period is considered an unfair payment pattern.

The examination disclosed that the Plan modified or rescinded authorizations in three claims after service was rendered by the provider submitting the claim. The claims in which this occurred were PD-39, D-5, and D-20.

This violation was referred to the Office of Enforcement for appropriate administrative action.

The Preliminary Report required the Plan to submit its revised policy to ensure that authorizations are not rescinded or modified after the provider has rendered the service in good faith. In addition, the Plan was required to indicate the date of implementation, the management position responsible for compliance, and the controls implemented for monitoring continued compliance.

The Plan stated it agrees with and acknowledges the deficiency finding regarding Rescission or Modification of Authorization.

The Plan responded that it will adhere to section 1371.8 and will reimburse claims accordingly. In the event that the Plan discovers other coverage after the authorization was issued and the provider has rendered the service, the Plan will work directly with the other Payer and the provider to ensure that the Plan recovers any overpayment.

The Plan's response included as Attachment III for the Plan's Policy & Procedure for Treatment Authorization Requests.

The Plan identified the Chief Financial Officer and the Claims Manager as the management positions responsible for monitoring and complying with the stated requirements.

The Department finds that the Plan's compliance effort is responsive to the corrective action required.

B. OTHER CLAIM PAYMENT ISSUES

1. REQUEST FOR FORM W-9

Rule 1300.71(a)(10) states the definition for “reasonably relevant information" and Rule 1300.71(a)(11) states the definition for "information necessary to determine payer liability."

The examination found that the Plan is requiring the submission of a W-9 for paying a claim. The Department does not consider a W-9 to be "reasonably relevant information" as defined by Rule 1300.71(a)(10) or "information necessary to determine payer liability" as defined in Rule 1300.71(a)(11), when the provider has submitted a claim with his/her tax identification number (“TIN”). A W-9 is an IRS requirement and not a Federal billing guideline requirement. However, the Department acknowledges the Plan’s right to request such information in the cases where the Plan believes that the TIN is not accurate or when possible fraud exists, or if the TIN is missing from the claim form. This issue was identified in late paid claims samples LP-10 and LP-70.

The Preliminary Report required the Plan to submit its revised policy to ensure that requests for W-9 are not required unless for the reasons stated above. In addition, the Plan was required to indicate the date of implementation, the management position(s) responsible for compliance, and the controls implemented for monitoring continued compliance.

The Plan stated it agrees with and acknowledges the deficiency finding regarding the request for Internal Revenue Services' (IRS) W-9 Form. The Plan stated that as a County of Los Angeles entity, it is required to facilitate all contracted and non-contracted medical service providers and other payments through the County's official accounting record keeping system known as the Electronic Countywide Accounting and Purchasing System (eCAPS). The eCAPS is managed/controlled by the County Auditor-Controller’s (A-C) office.

Effective September 1, 2011, the Plan represented that it will not initially require a W-9 Form from new providers submitting claims, but will rely on the information supplied on the claim form to request the A-C to create new vendor and address codes in eCAPS. The A-C reviews and verifies the supplied vendor's information by performing a Taxpayer Identification Number (TIN) match through an IRS web portal to authenticate both the entity's TIN and name per the IRS records. If the A-C informs the Plan that the entity's information does not match the IRS records, the W-9 Form will be requested.

The Plan stated that a W-9 Form will be requested from providers when an existing vendor record needs to be modified in eCAPS because the vendor relocated (when this condition exists the A-C requires a W-9 Form be submitted with the change order); and in this case, if the statutory days for claims payment are exceeded, appropriate interest will be paid with the claim. Additionally, the Plan stated that a W-9 Form will be

requested from providers when the Plan suspects the TIN is inaccurate, or when possible fraud exists, or when the TIN is missing from the claim form.

The Plan's response included as Attachment VI for the Plan's Policy & Procedure for Vendor-Customer Code Set Up.

The Plan identified the Chief Financial Officer and the General Accounting Supervisor as the management positions responsible for monitoring and complying with the stated requirements.

The Department finds that the Plan's compliance effort is responsive to the corrective action required.

C. INCURRED BUT NOT REPORTED CLAIMS LIABILITY

Rule 1300.77.2 states that each plan subject to subdivision (b) of Section 1377 shall calculate the estimate of incurred but not reported ("IBNR") claims pursuant to a method held unobjectionable by the Director.

The Department's review of Schedule I of the DMHC Report Format for the Quarterly Statement at December 31, 2010 finds that the Plan reports it over-accrued total claims liability (claims payable plus IBNR claims liability plus other medical liabilities) as compared with actual amounts paid to date by an average of 62% for the four (4) quarters ended December 2009 to September 2010. The Plan reported over-accruals of total claims liability for the quarters ended December 2009 to September 2010 of $6,935,828 (46%), $16,704,816 (72%), $14,825,950 (67%), and $10,592,939 (62%), respectively.

As part of our examination, the Department performed hindsight analysis of the Plan's reported total claims liability at December 31, 2010 and prior periods using actual paid claim data for the period of November 2008 through January 2011, as provided by the Plan. The Department used this historical data to validate the Plan's reported total claims liability and found an average over-accrual of 65% for the four (4) quarters ended December 2009 to September 2010 and is not significantly different from what the Plan reported in Schedule I for the quarter ended December 31, 2010. The Department's finding of an average over-accrual of 65% is not materially different from the Plan's average over-accrual of 62%, as determined from the Plan's Schedule I, as presented above.

As of the quarter ended December 31, 2010, the Plan reported total claims liability of $12,391,631 (claims payable plus IBNR claims liability) and the Department determined this liability at $6,057,821, which indicates the Plan over-accrued this liability by $6,333,810, or 51%.

The Preliminary Report required the Plan to review their methodology of determining the accrual for total claims liability and provide a description of the procedures implemented to ensure the estimate for this liability is reasonably reported at each reporting period, beginning with the quarter report for September 30, 2011. The Plan was also to state the

date of implementation of these procedures and the management position(s) responsible for monitoring continued compliance.

The Plan agrees with this finding and acknowledges the deficiency finding regarding the over-accrued IBNR liability. Except, the Plan finds that the DMHC "determined…liability at $6,057,821" is understated; since the actual payments for the period in question as of June 30, 2011 were $7.9 million paid with an expected IBNR remaining for the period of $1.3 million for a period total of $9.2 million.

As of September 30, 2010, the Plan estimated its IBNR lag model from historical data that lags the date of service to the date the claim was received (claims received method). The over-accrued IBNR during the period of December 2009 to September 2010 is because of the spike in submitted claims. The providers submitted the claims faster (as soon as the service was rendered) in order to be reimbursed sooner (due to the bad economy). The lag study formulas are based on the historical trend of claims received; where for instance, the 1st month (most recent month) usually represents 3% of the total anticipated collections of claims for that month of service. The fact that more claims were being submitted in the same month of service caused an increase of the overall estimates and projections.

Since October 2010, the Plan has reviewed new methodologies to reduce the over-accrued IBNR liability. Initially, the Plan changed to the paid claims method, which lagged the date of services to the date the claim was paid, and this method was used to estimate the IBNR for the quarter ending December 2010. Starting from January 1, 2011, the Plan adopted a new hybrid methodology which combined both claims received and claims paid methods. The Plan's IBNR dropped significantly to reflect the actual liability.

The Plan identified the Chief Financial Officer and the General Accounting Supervisor as the management positions responsible for monitoring the continued compliance.

The Department finds that the Plan's compliance effort is responsive to the corrective action required.

D. FINANCIAL STATEMENT PRESENTATION

Rules 1300.84.06 and 1300.84.2 sets forth the requirements for the filing of annual and quarterly financial statement with the Department. Rule 1300.84.2 states that the quarterly financial statements are to be prepared in accordance with generally accepted accounting principles and on a basis consistent with the certified financial report furnished by the plan pursuant to Section 1384(c). Rule 1300.84.06(b) sets forth the requirements for the supplemental information that is to accompany the DMHC Reporting Form

Our examination disclosed the following concerns with the DMHC Reporting Form and Supplemental Information filed for the quarter ending December 31, 2010:

1. An explanation of the method of calculating the provision for incurred but not reported claims was not provided as required in supplemental information item A1.

2. The Plan is not completing columns 7 to 12 of the Report #4: Enrollment and Utilization Table.

***CORRECTIVE ACTION TAKEN DURING EXAMINATION*:** The Plan provided an explanation of the method of calculating the provision for incurred but not reported claims in item A.1. of the Supplemental information that accompanies the DMHC Reporting Format filed with the Department for the quarter ended June 30, 2011**.**

The Preliminary Report required the Plan to state the corrective action taken to ensure that Report #4 is properly completed in the DMHC Report Form on all future financial statements, beginning with quarter ended September 30, 2011. The Department recommended that the Plan refer to the "General Information, Definition and Instruction" guide that provides instructions for proper completion of the DMHC Report Form.

The Plan was also to state the date corrective action was implemented and the management position(s) responsible for ensuring continued compliance.

The Plan agrees with this finding and acknowledges the deficiency finding regarding the presentation of Report #4: Enrollment and Utilization Table. The Plan did not include the Ambulatory Encounter data in the Quarterly Financial Report to DMHC (Report 4, column 7-12) because the data was incomplete within 3 to 6 months. However, in the past the Plan has always reported the Ambulatory Encounter data in the Annual Financial Report to DMHC (Report 4, column 7-12), when the data was complete.

Effective from the quarter ending September 30, 2011, the Plan will report the Ambulatory Encounter data on Column 7-12 of the Report #4 despite the 3 to 6 month data lag with an explanation on Notes section denoting that the data is incomplete. The more completed data will be reported annually to DMHC in the Annual Financial Report.

The Plan identifies the Chief Financial Officer and the General Accounting Supervisor as the management positions responsible for ensuring the continued compliance.

The Department finds that the Plan's compliance effort is responsive to the corrective action required.

SECTION IV. NON-ROUTINE EXAMINATION

The Plan is advised that the Department may conduct a non-routine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to this report. The cost of such examination will be charged to the Plan in accordance with Section 1382(b).

No response required to this Section.